Long-acting ß$_2$-agonist use in South African children

To the Editor: As doctors involved in the management of children with asthma, we have noted with concern the recent debate on and adverse publicity given to the long-acting ß$_2$-agonists (LABAs) used to treat children with asthma. We feel that the isssue needs clarification.

A meta-analysis[1] was recently published revealing an increased risk of hospitalisation and death in children receiving long-term LABAs for asthma control. This comes hot on the heels of debate around the real extent of LABA benefit in children.[2] The latter editorial suggested equivocal evidence of value of LABAs in asthma control in children and that LABA efficacy data have been extrapolated from adult studies.

In placing this issue in context, we need to state that there is a need for additional controller medications in moderate and severe persistent childhood asthma, largely because inhaled corticosteroids (ICSs) at higher doses have unwanted adverse events. In addition, other controller agents have not yet been documented as efficacious when added to ICS for more severe asthma in children (montelukast) or carry their own adverse potential (theophylline). All asthma guidelines (South African and international)[3,4] recommend LABAs in moderate and severe persistent childhood asthma in combination with ICSs. Many, if not most, studies on LABAs involve subjects with moderate and severe persistent asthma – the group most likely to have more severe disease. Although we are cognisant of the alleged new evidence of increased severe adverse events it must be stated that these studies are methodologically flawed and many do not include patients making regular use of ICSs.[5]

We would like to affirm and place on record our support for LABA use in children with asthma. We reaffirm the guideline suggestion[3] to limit LABA use (always in combination with ICSs) to moderate and severe persistent childhood asthma cases. In practice this will be less than one-third of asthmatic children. However there is a need to optimise ICS delivery and address issues of adherence and co-morbid conditions before low-dose ICS monotherapy is abandoned. We urge all role players (both doctors and pharmaceutical companies) to adhere to guidelines in this regard.[3]

In order to remain vigilant to potential risk we suggest that there is a need to assess asthma control more comprehensively in all patients using LABAs. No patient receiving a LABA should have a repeat prescription without adequate assessment of control (both detailed questioning and lung function testing are acceptable). We need to inform all caregivers that this problem is not solved by selecting an alternative therapy for the reasons outlined above. Be especially careful when using LABA off label, especially with regard to young children (less than 4 years old). These are typically children who should be assessed by paediatricians versed in managing children with wheezy disorders.

The South African Childhood Asthma Working Group is currently working on a revision/addendum to the existing South African Paediatric Asthma Management Guidelines.[3] This statement is in no way designed to replace that document. It is presented simply to address a current and topical issue. All South African doctors who manage children with asthma are urged to read the new guidelines carefully when they are published. Finally, we would like to advocate urgent research to address this issue more closely.

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