Results. The study families were predominately white (50%) or African American (35%). All of the children demonstrated positive skin test results for dust mite allergen, 61% (n = 69) had been examined and skin-tested by an allergist before enrolling in the study, and 4% were currently receiving immunotherapy. Fifty-six of the 69 families (81%) that had visited an allergist reported receiving advice regarding general indoor environmental control, compared with 22 families (49%) that had not visited an allergist (P < .0001). With respect to specific dust mite recommendations, families that had been evaluated by an allergist had significantly more dust mite knowledge (70% vs 18%, P < .0001). Families that had visited an allergist demonstrated a significantly greater frequency of knowledge regarding the need for mattress encasement (61% vs 13%, P < .0001) and pillow encasement (51% vs 11%, P < .0001), compared with the non-allergist-treated group. Families that had visited an allergist demonstrated somewhat greater implementation of dust mite control recommendations, compared with families that had visited a pediatrician (68% vs 56%, P = .063%). The use of mattress and pillow encasements was significantly greater (38% vs 11%, P = .001, and 36% vs 16%, P = .009, respectively) in the allergist-treated group than in the pediatrician-treated group. To evaluate adherence, comparisons of each family’s knowledge of specific recommendations with the changes made in the household were made. Of the families that had visited an allergist, 70% had knowledge of dust mite control measures and 60% of those families made at least 1 of the 4 observable changes in their households to reduce dust mite allergen exposure. Of the families that had visited a pediatrician, 18% had knowledge of dust mite control recommendations and 63% of those families made changes in their households.

Conclusions. Parents of dust mite-sensitive, asthmatic children who visited an allergist were more aware of dust mite allergen control recommendations and made more indoor environmental changes. Allergists are able to perform specific tests to determine allergies and can offer directed education regarding environmental control measures.

Reviewer’s Comments. This study emphasizes the importance of identifying allergy triggers. Without knowledge of specific allergy triggers, guidelines for environmental controls can only be vague. When given specific advice, patients appeared to be equally motivated, regardless of which physician provided the environmental control advice. However, a limitation of the study, as the authors noted, was that the subjects in the study were predominantly middle-class children; patients in lower socioeconomic groups might have different outcomes. In addition, depending on the type of insurance (if any), patients might not have easy accessibility to an allergist.

Helen Skolnick, MD
Princeton, NJ

Fungal Levels in the Home and Lower Respiratory Tract Illnesses in the First Year of Life


Purpose of the Study. Previous studies found a relationship between home dampness and lower respiratory tract symptoms among children. Is this relationship attributable to exposure to fungi, which thrive in damp conditions?

Study Population. A birth cohort of 499 children with a history of asthma or allergy for at least 1 parent was studied.

Methods. During a home visit, when the child was 2 or 3 months of age, a technician determined household and socioeconomic characteristics and obtained air and dust samples. Every 2 months thereafter, a follow-up telephone questionnaire, regarding respiratory symptoms and illnesses experienced by the child, was administered to the child’s primary caregiver. In-home fungal concentrations were evaluated as predictors of lower respiratory tract illnesses (LRIs) (croup, pneumonia, bronchiolitis, and bronchitis) in the first 1 year of life.

Results. In multivariate analyses, after controlling for gender, the presence of water damage or visible mold/mildew, being born in winter, breastfeeding, and being exposed to other children through siblings, the authors found a significantly increased relative risk (RR) of LRI with high levels (>90th percentile) of airborne Penicillium (RR: 1.73; 95% confidence interval [CI]: 1.23–2.43), dustborne Cladosporium (RR: 1.52; 95% CI: 1.02–2.25), Zygomyces (RR: 1.96; 95% CI: 1.35–2.83), or Alternaria (RR: 1.51; 95% CI: 1.00–2.28), or any fungus (RR: 1.86; 95% CI: 1.21–2.88).

Conclusions. Exposure to high fungal levels increased the risk of LRI in infancy. The actual mechanisms remain unknown.

β-Adrenergic Agonist Therapy

Comparison of Racemic Albuterol and Levalbuterol for Treatment of Acute Asthma


Purpose of the Study. Inhaled β-receptor agonists are widely used to treat bronchospasm and acute asthma exacerbations. Recently, a new β agonist, levalbuterol, which is the R-isomer of albuterol, was introduced. This study was conducted in an acute setting, to compare albuterol and levalbuterol.

Methods. This was a randomized, double-blind, controlled trial conducted in the emergency department and inpatient asthma care unit of a children’s hospital. Children were 1 to 18 years of age; the study group included 482 patients, with a total of 547 enrollments. Patients received a nebulized solution of either 2.5 mg of racemic albuterol or 1.25 mg of levalbuterol every 20 minutes, for a maximum of 6 doses. Children subsequently admitted to...
the asthma care unit were treated in a standardized manner, with continued administration of the drugs assigned in the emergency department. The primary outcome parameter was hospitalization rate.

Results. The hospitalization rate was significantly lower for the levalbuterol group (36%) than for the racemic albuterol group (45%, \( P = .02 \)). The adjusted relative risk of admission for the racemic albuterol group, compared with the levalbuterol group, was 1.25 (95% confidence interval: 1.01–1.57). There was no difference in the lengths of hospital stays, and there were no significant adverse events in either group.

Conclusion. Substituting levalbuterol for racemic albuterol in the emergency department treatment of acute asthma significantly reduced the number of hospitalizations.

Reviewer’s Comments. Additional prospective trials, including pulmonary function studies and economic analyses, will be necessary to justify the use of levalbuterol, rather than albuterol, as standard practice.

Christopher Randolph, MD
Waterbury, CT

COMPARATIVE EFFICACY OF TERBUTALINE SULFATE DELIVERED BY TURBUHALER DRY POWDER INHALER OR PRESSURIZED METERED-DOSE INHALER WITH NEBUHALER SPACER IN CHILDREN DURING AN ACUTE ASTHMATIC EPISODE


Purpose of the Study. Several previous studies demonstrated that the bronchodilator effect of a metered-dose inhaler (MDI) with spacer was just as good as that of a nebulizer for treatment of acute asthma exacerbations among children. What about a DPI versus a MDI with spacer or a nebulizer for treatment of acute asthma exacerbations in children.

Methods. Among children 6 to 16 years of age, who presented to an emergency department with asthma exacerbations were studied. Baseline forced expiratory volume in 1 second (FEV1) values were 25 to 60% of predicted values.

Methods. Patients were randomized to receive terbutaline through either a MDI with spacer or a DPI (Turbuhaler, AstraZeneca, Lund, Sweden). Doses were administered at 0 and 30 minutes, and FEV1 values were measured at 0, 30, and 60 minutes.

Results. No differences in increases in FEV1 were seen at 30 minutes (MDI with spacer: 35%; DPI: 33%) or 60 minutes (MDI with spacer: 50%; DPI: 49%). There were also no differences in oxygen saturation or heart rates.

Conclusion. For treatment of acute asthma exacerbations among children ≥6 years of age, delivery of a bronchodilator with a DPI works just as well as delivery with a MDI with spacer.

Reviewer’s Comments. The Environmental Protection Agency and the Food and Drug Administration are mandating that current MDIs be phased out, because of the adverse environmental effects of chlorofluorocarbon propellants. Inhaler manufacturers have complied either by using more environmentally friendly propellants (such as hydrofluoroalkanes) or by eliminating the propellant entirely in DPIs. It is reassuring to know that, even in acute asthma exacerbations, children ≥6 years of age can effectively use a DPI for delivery of bronchodilator.

John M. Kelso, MD
San Diego, CA

RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED TRIAL OF ORAL ALBUTEROL IN INFANTS WITH MILD-TO-MODERATE ACUTE VIRAL BRONCHIOLITIS


Purpose of the Study. To determine whether oral albuterol therapy is effective in reducing symptoms of mild/moderate acute viral bronchiolitis.

Study Population. A total of 129 previously healthy infants (≤12 months of age) discharged directly home from the emergency department (ED), with a clinical diagnosis of acute viral bronchiolitis, were studied.

Methods. At discharge from the ED, patients were randomly assigned to receive either oral albuterol therapy (0.1 mg/kg per dose) or oral placebo treatment. Infants were treated 3 times daily for a maximum of 7 days or until complete resolution of bronchiolitis symptoms, whichever happened first. Overall health, medication compliance, feeding and sleeping patterns, follow-up visits, parental life disruptions, and adverse events were discussed in daily telephone interviews until the resolution of symptoms or for 14 days. The primary outcome of interest was the time from study enrollment until the resolution of illness, as determined by the primary caregiver. Secondary outcomes of interest included duration of cough, coryza, and noisy breathing, time to normal feeding, and time to normal sleeping.

Results. During the study, 1039 infants were discharged from the hospital ED with acute viral bronchiolitis. Of those, 231 were eligible and 129 were randomized into the study. The mean ages were 5.4 months for the albuterol group and 5.1 months for the placebo group. Respiratory syncytial virus was the pathogen found most frequently (albuterol: 81%; placebo: 79%) in nasopharyngeal aspirates collected from 61 infants in the 2 groups. The median number of days of illness before ED presentation for both groups was 4.0 days. The mean times to the resolution of illness were similar for the 2 groups (albuterol: 8.9 days; placebo: 8.4 days). There were no significant differences in secondary outcomes between the groups. Hospitalization for treatment of respiratory distress was eventually required for 4 infants in the albuterol group and 5 in the placebo group. There were similar median numbers of health care revisits for the 2 groups (albuterol: 1; placebo: 0). There were also similar median numbers of days in which trembling and vomiting were observed (albuterol: 0 and 1; placebo: 0 and 0, respectively).

Conclusions. There was no significant difference in symptom resolution for newly diagnosed bronchiolitis treated with orally administered albuterol versus placebo. The authors did not recommend the use of orally administered albuterol for this patient population.

Reviewers’ Comments. Although previous studies found similar results, most outcomes in this study were based solely on subjective evaluations by the primary caregiver at home. The authors present compelling evidence that orally administered albuterol, at the dose used in this study, has little role in the treatment of bronchiolitis among infants. However, the dose of albuterol was at the low end of the recommended dose range of 0.1 to 0.2 mg/kg per dose, administered 3 times daily.

Joseph Shapiro, MD
Michael S. Kaplan, MD
Los Angeles, CA
COMPARISON OF RACEMIC ALBUTEROL AND LEVALBUTEROL FOR TREATMENT OF ACUTE ASTHMA
Christopher Randolph
Pediatrics 2004;114;541

Updated Information & Services
including high resolution figures, can be found at:
/content/114/Supplement_1/541.2.full.html

Subspecialty Collections
This article, along with others on similar topics, appears in the following collection(s):
Pharmacology
/cgi/collection/pharmacology_sub
Toxicology
/cgi/collection/toxicology_sub
Asthma
/cgi/collection/asthma_sub

Permissions & Licensing
Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at:
/site/misc/Permissions.xhtml

Reprints
Information about ordering reprints can be found online:
/site/misc/reprints.xhtml

PEDIATRICS is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. PEDIATRICS is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2004 by the American Academy of Pediatrics. All rights reserved. Print ISSN: 0031-4005. Online ISSN: 1098-4275.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
COMPARISON OF RACEMIC ALBUTEROL AND LEVALBUTEROL FOR TREATMENT OF ACUTE ASTHMA
Christopher Randolph
Pediatrics 2004;114;541

The online version of this article, along with updated information and services, is located on the World Wide Web at:
/content/114/Supplement_1/541.2.full.html