A Systematic Review of Long-Acting \( \beta_2 \)-Agonists Versus Higher Doses of Inhaled Corticosteroids in Asthma

**abstract**

**OBJECTIVE:** To compare the efficacy of inhaled corticosteroids (ICS) plus long-acting \( \beta_2 \) agonist (LABA) versus higher doses of ICS in children/adolescents with uncontrolled persistent asthma.

**METHODS:** Randomized, prospective, controlled trials published January 1996 to January 2012 with a minimum of 4 weeks of LABA +ICS versus higher doses of ICS were retrieved through Medline, Embase, Central, and manufacturer’s databases. The primary outcome was asthma exacerbations requiring systemic corticosteroids; secondary outcomes were the pulmonary function test (PEF), withdrawals during the treatment period, days without symptoms, use of rescue medication, and adverse events.

**RESULTS:** Nine studies (\( n = 1641 \) patients) met criteria for inclusion (7 compared LABA+ICS versus double ICS doses and 2 LABA+ICS versus higher than double ICS doses). There was no statistically significant difference in the number of patients with asthma exacerbations requiring systemic corticosteroids between children receiving LABA +ICS and those receiving higher doses of ICS (odds ratio = 0.76, 95% confidence interval: 0.48–1.22, \( P = .25, I^2 = 16\% \)). In the subgroup analysis, patients receiving LABA+ICS showed a decreased risk of asthma exacerbations compared with higher than twice ICS doses (odds ratio = 0.48, 95% confidence interval: 0.28–0.82, \( P = .007, I^2 = 0 \)). Children treated with LABA+ICS had significantly higher PEF, less use of rescue medication, and higher short-term growth than those on higher ICS doses. There were no other significant differences in adverse events.

**CONCLUSIONS:** There were no statistically significant group differences between ICS+LABA and double doses of ICS in reducing the incidence of asthma exacerbations but it did decrease the risk comparing to higher than double doses of ICS. *Pediatrics* 2012;130:e650–e657

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**KEY WORDS**

asthma, children, adolescents, LABA, inhaled corticosteroids, efficacy

**ABBREVIATIONS**

AEs—adverse events

BDP—beclomethasone dipropionate

CI—confidence interval

FDA—Food and Drug Administration

FEV\(_1\)—flow expiratory volume in the first second

ICS—inhaled corticosteroids

LABA—long-acting \( \beta_2 \) agonist

OR—odds ratio

PEF—peak expiratory flow

RCT—randomized controlled trial

RR—relative risk

WMD—weighted mean differences

Dr Castro-Rodriguez has made substantial contributions to the conception, design, and interpretation of data; has revised the article critically for important intellectual content, and has provided final approval of the version to be published.

Dr Rodrigo has made substantial contributions to the conception and design, acquisition of data, analysis and interpretation of data; has drafted the submitted article and revised it critically for important intellectual content; and has provided final approval of the version to be published.

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According to the most commonly used international asthma guidelines,1–3 children with persistent asthma should be started on controller therapy with inhaled corticosteroids (ICS) as the preferred drug, with leukotriene modifiers (eg, montelukast) as an alternative for patients who are unable or unwilling to use ICS. A recent meta-analysis concludes that children receiving ICS showed a significantly decreased risk of asthma exacerbation requiring systemic corticosteroids than children receiving montelukast.4 As well, children treated with ICS had significantly higher pulmonary function and better clinical parameters compared with those receiving montelukast.4 Moreover, the latest study comparing ICS and montelukast showed that fluticasone (100 μg twice daily) was the most effective therapy; however, uncontrolled asthma occurred in more than 50% of the children, and 39% of the children had at least 1 asthma exacerbation that was treated with oral corticosteroids during a 48-week period.5

In cases where ICS is not sufficient to control the disease in children, international guidelines recommend increasing the dose of ICS or adding leukotriene modifiers or long-acting β agonists (LABAs).1–3 A previous systematic review4 showed that in children, but not in adults, LABA added to ICS had not significantly reduced the risk of exacerbations requiring a short course of systemic corticosteroids (relative risk [RR] = 1.28, 95% confidence interval [CI] 0.58–2.66) compared with the use of higher doses of ICS. Moreover, children could be almost 3 times more likely than adults to require oral steroids when they were treated with a LABA than with ICS; however, some children included in the meta-analysis came from trials performed in mixed population (children and adults together).

In recent years, more studies enrolling children exclusively have appeared in the literature. Therefore, it is important to know which option (increased doses of ICS or the addition of LABA) is better for step 3 of the guidelines for children when low doses of ICS do not control their asthma.

The objective of this systematic review was to assess the safety and efficacy of the LABA/ICS combination compared with an increased dose of ICS (double or greater) in children and adolescents with uncontrolled persistent asthma.

**METHODS**

**Search and Selection Criteria**

We identified studies from Medline, Embase (search January 2012), and the Cochrane Controlled Trials Register (CENTRAL) (search January 2012 databases using the following medical subject headings, full text, and keywords: long-acting β-2 agonists OR salmeterol OR formoterol OR indacaterol AND corticosteroids OR fluticasone OR budesonide OR ciclesonide OR mometasone OR beclomethasone OR flunisolide OR triamcinolone). The search was then limited with the terms children OR child OR pediatric OR adolescents OR infants OR preschoolers. As well, we performed a search of relevant unpublished files from drug manufacturer databases (http://gsk-clinicalstudyregister.com/result_compounds.jsp; http://www.astrazenecaclinicaltrials.com; and http://www.novartiscinicaltrials.com). Trials published solely in abstract form were excluded because the methods and results could not be fully analyzed. The specific inclusion criteria were as follows: (1) children and adolescents aged 4 to 18 years with persistent asthma and having received ICS daily; (2) the addition of LABA to ICS compared with a higher doses of ICS; (3) studies with at least 4 weeks’ duration; (4) randomized (parallel group or crossover) controlled trials (RCTs) without language restriction. The primary outcome of the study was proportion of subjects with asthma exacerbations requiring the use of systemic corticosteroids. Secondary outcome measures were the following: withdrawals during treatment period, pulmonary function tests (FEV1 or PEF), days without asthma symptoms, use of rescue medication, adverse events (AEs), and severe AEs. A serious AE was defined as any untoward medical occurrence that sometimes results in death, is life-threatening, requires inpatient hospitalization, or results in persistent or significant disability/incapacity.7

**Data Abstraction and Assessment of Risk of Bias**

This systematic review was performed according to Preferred Reporting Items for Systematic Reviews and Meta-analyses guidelines.8 Titles, abstracts, and citations were independently analyzed by all reviewers. From the full texts, the reviewers independently assessed all studies for inclusion based on the criteria for population intervention, study design, and outcomes. After obtaining full reports about potentially relevant trials, they assessed eligibility. The authors were independently involved in all stages of study selection, data extraction, and risk of bias assessment. The latter was assessed according to recommendations outlined in the Cochrane Handbook.9 Disagreements were resolved by group consensus. In the case of multiple published or unpublished reports, data from the most recent version were extracted.

**Data Analysis**

The present analysis was done by intention to treat with all participants, including withdrawals, to minimize bias owing to differences among groups. We calculated the Mantel-Haenszel odds ratios (ORs) and 95% CIs for binary outcomes. When effect estimates were significantly different between groups,
the number needed to treat to benefit or to harm was obtained. Continuous outcomes were pooled using weighted mean differences (WMDs) and 95% CIs. Heterogeneity was measured by the I² test (<40% could be unimportant, 40% to 60% could be moderate, and 60% to 100% could be substantial).10 Because selected studies differed in the mixes of participants and interventions, a random-effects meta-analysis was performed to address this variation across studies in all outcomes.11 We used a priori subgroup analysis to explore the influence of the ICS dose (double versus more than double), type of LABA (salmeterol versus formoterol), length of treatment (<24 weeks versus ≥24 weeks), age range (4–11 vs 11–17 years), and severity of airway obstruction (prebronchodilator FEV₁; and morning and evening PEF from baseline) Subgroups were compared by using the interaction test.12 Additional predefined sensitivity analyses were done to explore the influence on effect size of risk of bias (low-risk trials versus high-risk trials), and the statistical model (fixed versus random effects). A low-risk bias was defined as a minimum of 5 of 6 domains filled in an acceptable way. Publication bias of primary outcomes was evaluated by funnel plots.13 A P < .05 using a 2-tailed test was considered to indicate significance. Meta-analysis was performed with Review Manager 5.1.2 software (The Nordic Cochrane Centre, The Cochrane Collaboration, 2011, Copenhagen, Denmark).

RESULTS

Nine RCTs,14–22 involving a total of 1641 children and adolescents, fulfilled the inclusion criteria (Fig 1). One trial was unpublished.20 All studies examined the combination LABA/ICS in 1 device (Table 1). The mean age of participants was 9 years (range 4–17), with 59% being male. Eight trials14,16–22 included subjects with inadequately controlled asthma, low doses of ICS (200–500 µg/d beclomethasone dipropionate [BDP] or equivalent). The remaining study recruited children with mild asthma.15 Almost all studies tested the commonly recommended doses of LABAs (ie, salmeterol 50 µg twice daily, or formoterol 9–12 µg twice daily). One study used the combination formoterol/budesonide as maintenance, plus additional doses as needed.21 Intervention groups received BDP equivalent doses of 400 µg/d in 7 studies14,16–20,22 and 200 µg/d in 2 studies.15,21 The dose of ICS that the control group received was twice,14–20 or more than twice, the amount received by the LABA/ICS group.21,22 Rescue medications, such as inhaled short-acting β2-agonists and systemic steroids, were permitted in all the trials. Most of the studies14,16–21 were funded by the pharmaceutical industry. Six studies16–18,20–22 were judged to have a low risk of bias (successfully complied with at least 5 of the 6 domains of bias assessment) (Table 2).

Primary Outcome

The analysis of 8 studies (n = 1616 subjects)14,16–22 showed no statistically significant differences in the number of patients with asthma exacerbations requiring systemic corticosteroids between children receiving LABA+ICS and those receiving higher doses of ICS (OR = 0.76, 95% CI: 0.48–1.22, P = .25) (Fig 2). There was no evidence of publication bias (Egger’s test, 0.35; 95% CI: –0.4 to 0.74) or significant heterogeneity among studies (I² = 16%). However, among the subgroup studies that compared LABA+ICS versus higher than a double dose of ICS, combination therapy significantly reduced the risk of exacerbations (OR = 0.48, 95% CI: 0.28–0.82, P = .007, I² = 0%) (Fig 3B). This difference was compatible with a number needed.
to treat of 9 (95% CI: 5–45). Post hoc subgroup analysis showed that subjects in studies testing higher than twice ICS doses had a significantly lower risk of asthma exacerbations than subjects in studies using a double ICS dose (OR = 0.38; 95% CI: 0.37–0.84, \( P = .01 \)).

A sensitivity analysis comparing age range groups (4–11 vs 11–17 years) was not possible to do, because the studies were not divided into these 2 age categories; in contrast, they had an age range not mutually exclusive (4–11 and 6–17 years). The duration of treatment (≥24 weeks versus <24 weeks) did not influence this effect size (OR = 0.53; 95% CI: 0.53–1.40, \( P = .20 \)). Because the number of studies was low, the impact of the baseline severity of airway obstruction by lung function and type of LABA on size effect could not be examined. In the same way, the effect size obtained using random or fixed effects models did not differ (OR = 0.92; 95% CI: 0.42–2.19, \( P = .9 \)). Sensitivity analysis based on the risk of bias showed different results; trials with low risk of bias \( ^{16–18,20–22} \) were not associated with a significantly low risk of exacerbation (OR = 0.68; 95% CI: 0.42–1.10, \( I^2 = 8% \)) compared with trials with high risk of bias \( ^{14,15,19} \) (OR = 0.84; 95% CI: 0.12–5.75, \( I^2 = 42% \)). There was no possibility of comparing trials sponsored by the pharmaceutical industry and independent studies, as only 1 of the 2 independent studies had data on exacerbations.

### Secondary Outcomes

The addition of LABA to ICS provided significantly greater improvements in morning PEF from baseline (Fig 4A) (WMD = 8.74; 95% CI: 4.87–12.51 L/min, \( I^2 = 0% \)) and evening PEF from baseline (WMD = 4.41; 95% CI: 1.77–7.05 L/min, \( I^2 = 0% \)) at the end point (Fig 4B), compared with higher ICS doses. The duration of interventions did not affect the magnitude of this improvement over

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**TABLE 1**

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Location and Duration</th>
<th>Patients, n (% Male)</th>
<th>Mean Age, y (Range)</th>
<th>Atopy status (%)</th>
<th>Mean Baseline FEV1 (% Predicted)</th>
<th>Selected Comparisons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verberne14</td>
<td>R, DB, PG</td>
<td>Multicenter</td>
<td>120 (63)</td>
<td>11.1 (6–16)</td>
<td>89</td>
<td>88.5</td>
<td>SALM/BDP 50/200 µg BID versus BDP 400 µg BID</td>
</tr>
<tr>
<td>Heuck15</td>
<td>R, DB, CO</td>
<td>SC</td>
<td>27 (52)</td>
<td>9.6 (6–13)</td>
<td>NR</td>
<td>88.5</td>
<td>FORM/BUD 12/100 µg BID versus BUD 200 µg BID</td>
</tr>
<tr>
<td>Vaessen-Verberne16 (SAM 101667)</td>
<td>R, DB, PG</td>
<td>Multicenter</td>
<td>158 (58)</td>
<td>9.3 (6–16)</td>
<td>75</td>
<td>100</td>
<td>SALM/FLUT 50/100 µg BID versus FLUT 200 µg BID</td>
</tr>
<tr>
<td>de Blic17</td>
<td>R, DB, PG</td>
<td>Multicenter</td>
<td>303 (64)</td>
<td>8.1 (4–11)</td>
<td>88</td>
<td>1.7 liters</td>
<td>SALM/FLUT 50/100 µg BID versus FLUT 200 µg BID</td>
</tr>
<tr>
<td>Gappa18</td>
<td>R, DB, PG</td>
<td>Multicenter</td>
<td>283 (68)</td>
<td>9.5 (4–16)</td>
<td>NR</td>
<td>91</td>
<td>SALM/FLUT 50/100 µg BID versus FLUT 200 µg BID</td>
</tr>
<tr>
<td>Murray19</td>
<td>R, DB, PG</td>
<td>Multicenter</td>
<td>24 (50)</td>
<td>7.3 (4–11)</td>
<td>75</td>
<td>82</td>
<td>SALM/FLUT 50/100 µg BID versus FLUT 200 µg BID</td>
</tr>
<tr>
<td>GSK SAM 400120</td>
<td>R, DB, PG</td>
<td>Multicenter</td>
<td>367 (69)</td>
<td>7.7 (4–11)</td>
<td>75</td>
<td>NR</td>
<td>SALM/FLUT 50/100 µg BID versus FLUT 200 µg BID</td>
</tr>
<tr>
<td>Bisgaard21</td>
<td>R, DB, PG</td>
<td>Multicenter</td>
<td>224 (69)</td>
<td>8 (4–11)</td>
<td>NR</td>
<td>76</td>
<td>FORM/BUD 4.5/80 µg BID plus additional doses as needed versus BUD 200 µg BID</td>
</tr>
<tr>
<td>Lemanske22</td>
<td>R, DB, CO</td>
<td>Multicenter</td>
<td>120 (40)</td>
<td>10.9 (6–17)</td>
<td>NR</td>
<td>96</td>
<td>SALM/FLUT 50/100 µg BID versus FLUT 200 µg BID</td>
</tr>
</tbody>
</table>

BID, twice daily; BUD, budesonide; CO, cross over; DB, double-blind; FEV1 = forced respiratory volume in the first second; FLUT, fluticasone; FORM, formoterol; NR, not reported; PG, parallel group; R, randomized; SALM, salmeterol; SC, single center.

**TABLE 2**

<table>
<thead>
<tr>
<th>Study</th>
<th>Random Sequence Generation</th>
<th>Allocation Concealment</th>
<th>Blinding of Participants &amp; Personnel</th>
<th>Blinding of Outcome Assessment</th>
<th>Incomplete Outcome Data Addressed</th>
<th>Selective Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verberne199814</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>U</td>
<td>N</td>
</tr>
<tr>
<td>Heuck200015</td>
<td>Y</td>
<td>U</td>
<td>Y</td>
<td>Y</td>
<td>U</td>
<td>N</td>
</tr>
<tr>
<td>Vaessen-Verberne201016</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>U</td>
<td>Y</td>
</tr>
<tr>
<td>DeBlic200917</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Gappa200918</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Murray201019</td>
<td>U</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>U</td>
<td>N</td>
</tr>
<tr>
<td>GSK SAM400120</td>
<td>Y</td>
<td>U</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Bisgaard200921</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Lemanske201022</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

N, No; U, Unknown; Y, Yes.
There were no statistically significant group differences in prebronchodilator FEV1 between LABA+ICS versus higher ICS doses (WMD = 0.46; 95% CI: 0.18–1.34 L/s; I² = 74%, P = .68); however, this information came from only 3 studies.14,16,17

There were no significant differences between the LABA+ICS and ICS groups in the following outcomes: (1) number of prematurely discontinued patients (4.4% vs 4.1%); (2) withdrawals due to AEs (1.1% vs 1.1%); (3) withdrawals because of asthma exacerbations (0.3% vs 1.0%); (4) percentage of days free of asthma symptoms (WMD = −5.03% [−10.99 to 0.93]); (5) AEs (54.6% vs 55.6%); and (6) severe AEs (2.0% vs 2.6%) (Table 3). On the other hand, the combination of LABA+ICS is associated with significantly lower, but modest, use of rescue medication (−0.11 puffs/d, 95% CI: −0.20 to −0.01) (Table 3). Finally, data from 3 trials showed that short-term growth was significantly greater in children treated with combination therapy compared with children treated with higher ICS doses (WMD = 0.66 cm/y [95% CI: 0.08–1.25]) (Table 3). In almost all of the variables, the degree of heterogeneity was unimportant or null.

**DISCUSSION**

To our knowledge, this is the first meta-analysis performed of trials exclusively about child and adolescent populations to explore the efficacy of ICS+LABA compared with higher doses of ICS for uncontrolled persistent asthma. Overall, there were no statistically significant group differences between ICS+LABA and double or higher doses of ICS in reducing the incidence of asthma exacerbations requiring systemic corticosteroids.

Curiously, comparing 2 trials by using LABA+ICS versus higher than double doses of ICS, significant effects were observed that favor the combination therapy in reducing the risk of asthma exacerbation (number needed to treat of 9); however, the effect on asthma exacerbations was not observed when trials comparing LABA+ICS versus double doses of ICS were analyzed. The paradoxical effect is biologically difficult to explain. Potential explanation could be attributable to the inclusion of 2 particular studies. In the Bisgaard et al study,1 of the 2 groups with combination therapy used an adjustable

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**FIGURE 2**

Pooled ORs and 95% CIs for the number of patients with at least 1 asthma exacerbation (with 95% CI) requiring systemic corticosteroids comparing LABA+ICS versus higher doses of ICS.

**FIGURE 3**

Pooled ORs and 95% CIs for the number of patients with at least 1 asthma exacerbation (with 95% CI) requiring systemic corticosteroids comparing LABA+ICS versus double (A) or more than double dose of ICS (B).
rather than fixed dose of LABA+ICS during exacerbations (and probably between exacerbations) or step-up therapy during exacerbation, versus those in the group of ICS who received fixed ICS doses, given the possibility that children in the latter group received a lower total ICS dose. And in the Lemanske et al study, the design was cross sectional (child received for 16 weeks LABA+ 200 μg/d of fluticasone and for 16 weeks 500 μg/d of fluticasone or vice versa, with 4 weeks for wash-out) given the possibility that the wash-out period was not enough. When we exclude these 2 studies in our meta-analysis, no statistically significant group difference on asthma exacerbation was found between LABA+ICS versus higher doses of ICS. It is important to consider that a crossover study is probably the best design to explore individual response to drugs, however, and that trial showed the superiority of adding LABA to ICS versus higher doses of ICS in reducing asthma exacerbation requiring systemic corticosteroids.

Asthma exacerbations are common events in asthmatic patients and represent the greatest risk, and the highest asthma-related treatment cost for the health care system and for the community in general. Also, exacerbations are the most important cause of lost school days for asthmatic children. Asthma control has 2 aspects: current control in response to day-to-day symptoms through the use of rescue medications; and the burden imposed by these symptoms, and the risk of asthma exacerbations, irreversible decrease in lung function, and side effects from asthma medications. Therefore, the prevention of asthma exacerbations is an important component of establishing ideal asthma control. A control trial showed that in step 2 of asthma management (low ICS doses or leukotriene modifiers), more than 50% of children still have uncontrolled asthma and 39% have had at least 1 asthma exacerbation that was treated with oral corticosteroids during a 48-week period; for that reason it is very important to prevent exacerbations. A previous meta-analysis that included only 3 studies done in children showed that in step 2 of asthma management (low ICS doses or leukotriene modifiers), more than 50% of children still have uncontrolled asthma and 39% have had at least 1 asthma exacerbation that was treated with oral corticosteroids during a 48-week period; for that reason it is very important to prevent exacerbations.

### TABLE 3 Effect of LABA plus ICS Versus Higher ICS Doses on Secondary Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Studies</th>
<th>n (number of subjects)</th>
<th>Measure (95% CI)</th>
<th>P</th>
<th>I²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prematurely discontinued patients</td>
<td>14–21</td>
<td>1543</td>
<td>OR = 1.0 (0.57 to 1.74)</td>
<td>.99</td>
<td>46</td>
</tr>
<tr>
<td>Withdrawals owing to adverse events</td>
<td>14–15, 17, 21</td>
<td>713</td>
<td>OR = 1.01 (0.26 to 3.99)</td>
<td>.98</td>
<td>0</td>
</tr>
<tr>
<td>Withdrawals owing to asthma exacerbations</td>
<td>14,17,21</td>
<td>665</td>
<td>OR = 0.28 (0.04 to 1.63)</td>
<td>.15</td>
<td>0</td>
</tr>
<tr>
<td>Percent of days without asthma symptoms</td>
<td>14–16,18–21</td>
<td>1222</td>
<td>WMD = −5.03 (−10.99 to 0.93)</td>
<td>.10</td>
<td>0</td>
</tr>
<tr>
<td>Use of rescue medication, puffs/d</td>
<td>14–15,18–19,21</td>
<td>687</td>
<td>WMD = −0.11 (−0.20 to −0.01)</td>
<td>.02</td>
<td>0</td>
</tr>
<tr>
<td>AEs</td>
<td>14,16–21</td>
<td>1495</td>
<td>OR = 0.95 (0.73 to 1.25)</td>
<td>.23</td>
<td>25</td>
</tr>
<tr>
<td>Serious AEs</td>
<td>14,18–18,20–22</td>
<td>1593</td>
<td>OR = 0.76 (0.39 to 1.49)</td>
<td>.43</td>
<td>0</td>
</tr>
<tr>
<td>Linear growth rate, cm/y</td>
<td>15–16,21</td>
<td>430</td>
<td>WMD = 0.66 (0.08 to 1.25)</td>
<td>.02</td>
<td>0</td>
</tr>
</tbody>
</table>

n, number of subjects.

FIGURE 4
Pooled WMD and 95% CIs for the mean change in morning (A) and evening (B) PEF (L/min) from baseline.
therapy versus higher ICS doses. However, the current study included 8 trials done exclusively in children showing a trend of decreased risk of asthma exacerbations requiring systemic corticosteroids in the group of LABA+ICS versus higher doses of ICS (OR = 0.76; 95% CI: 0.48–1.22, P = .25). The difference may be attributable to the number and type of studies included. More trials need to be done to definitively lay down the best treatment in children with persistent asthma.

Another important direct effect of asthma exacerbations is the use of rescue medication and lung function deterioration. In the current study, we found a significant modest reduction in the use of rescue medication among children on LABA+ICS than those on higher doses of ICS. Also, we found a statistically significant but uncertain clinically significant improvement in lung function (morning and evening PEF) among children/adolescents using LABA+ICS compared with those using higher doses of ICS. ICS treatment has a plateau, such that increasing the dose does not necessarily improve the clinical response, and systemic effects can start. In contrast, the synergistic effect of adding LABA to ICS has been reported, where LABA, along with its bronchodilator effect, increases the nuclear translocation of the glucocorticoid receptor. At the same time, ICS is delivered in the same device and along with its anti-inflammatory effect, it increases the expression of β2-receptors by increasing gene transcription. These findings could explain the higher performance of the combination of LABA+ICS versus higher doses of ICS.

We were not able to perform a sub-analysis of main outcome comparing age groups (4–11 vs 11–17 years) because trials included in the meta-analysis had overlap in age (4–11 and 6–17 years). This is relevant because an international asthma guideline recommends increasing ICS doses first instead of adding LABA in children older than 5 years. Moreover, if we found that short-term growth was significantly greater in children with combination therapy (370 μg/d of BDP or equivalent) compared with children with higher ICS doses (770 μg/d of BDP or equivalent), this difference of 0.66 cm/y could be important, especially for children in their early years. However, long-term growth studies need to confirm this finding. Also, it is important to consider the strong evidence of the ICS molecule-dependant effect on growth.

Even though the studies included in the present meta-analysis have a wide range of duration (6 to 54 weeks), no statistically significant group differences in AEs and serious AEs were found between children on LABA+ICS versus higher doses of ICS. These findings are in accordance with the latest Food and Drug Administration (FDA) recommendation, including 1 exclusively done in children by the FDA where those trials with LABA plus “assigned ICS therapy” showed no presence of LABA risk. However, the FDA called on manufacturers of LABA to conduct large clinical trials to definitively determine whether the addition of LABAs to ICS increases the risk of serious asthma outcomes. Conversely, a recent study has summarized nearly 20 systematic reviews and databases on LABA safety and showed that there is no risk of serious asthma-related events when using LABA associated with ICS, particularly when concomitant use of LABAs+ICS can be reasonably ensured (combined in a single inhaler). Evidence from RCTs, meta-analysis of RCTs, and observational studies, although limited by low statistical power, indicate that the use of combination therapy (LABAs+ICS) in children and adults is associated with a decreased risk of serious asthma-related events.

CONCLUSIONS

This meta-analysis showed no statistically significant group differences between ICS+LABA and double doses of ICS in reducing the incidence of asthma exacerbations requiring systemic corticosteroids but it did decrease the risk comparing to higher than double doses of ICS. As well, children on combination therapy had significantly improved lung function (morning and evening PEF), reduced use of rescue medication and showed less effect on short-term linear growth rate than children on higher doses of ICS.

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A Systematic Review of Long-Acting β2-Agonists Versus Higher Doses of Inhaled Corticosteroids in Asthma

Jose A. Castro-Rodriguez and Gustavo J. Rodrigo

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