

The end of as required inhaled short-acting bronchodilator for asthma?

The recently published 2019 GINA guide to managing asthma has introduced a major change in their recommendations.¹ "For safety, GINA no longer recommends treatment with short-acting beta2-agonists (SABA) alone. There is strong evidence that SABA-only treatment, although providing short-term relief of asthma symptoms, does not protect patients from severe exacerbations, and that regular or frequent use of SABAs increases the risk of exacerbations. GINA now recommends that all adults and adolescents with asthma should receive either symptom-driven (in mild asthma) or daily low-dose ICS-containing controller treatment, to

reduce their risk of serious exacerbations." The reasons that GINA states for the change make perfect theoretical sense: mild asthma is associated with life-threatening and fatal attacks especially when there is a pattern of over reliance on SABA. The issue is that the change in guidance is based on one large, pharmaceutical study with three arms: as required SABA, as required SABA-inhaled corticosteroids and regular low-dose inhaled corticosteroids with as required SABA in patients deemed to need GINA step 2 therapy.² The as required SABA group had twice the risk of severe exacerbations. This is not proof though that the impact would have been

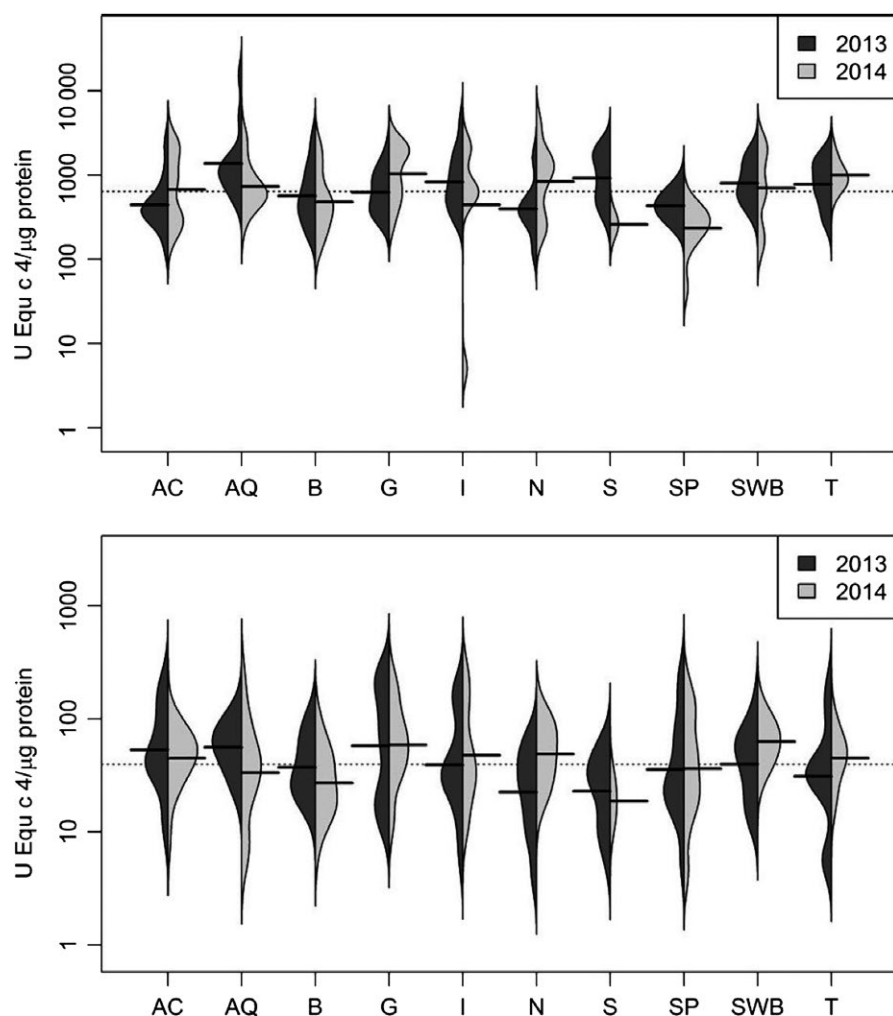


FIGURE 1 Levels of Equ c 4 in (A) dander and (B) saliva for each year in each breed. Dotted line shows the overall geometric mean value of all horses while the black lines show the geometric mean values for each breed and year. For more details, see Figure 3, Victor et al (page 705)

as great for a milder group of patients with only very intermittent symptoms. Would only very intermittent use of a SABA/inhaled corticosteroid combination inhaler give the same large reduction in exacerbations? This is an important question as many individuals with asthma have very intermittent symptoms. Surely we need at least one well-designed, large randomized controlled trial before such an important change is made to the asthma guidelines?

In this issue of the Journal, Maurer *et al* have undertaken an observational study of real-world antihistamine-refractory chronic spontaneous urticaria (CSU) management in German adults.^{3,4} CSU continued to be uncontrolled in nearly half the participants after a year of follow-up; quality of life similarly continued to be impaired. However, most patients did not receive guideline-recommended treatments such as higher dose antihistamine or omalizumab.⁵ There appears to be a problem with the implementation of the guidelines here.

Elegbede *et al*⁶ have explored the threshold at which individuals with peanut allergy react. Given that management is dominated by avoidance, a knowledge of the dose at which individuals react is important.⁷ The authors used MIRABEL survey data from 238 of 785 patients (mainly children) with peanut allergy or sensitization in France, Belgium and Luxembourg. The median threshold dose was 67 mg of peanut protein [interquartile range 16–244]. The objective ED01 (dose at which 1% of the patients are likely to react with objective symptoms) was 0.26 mg [0.03; 2.24]. Statistically, modelling suggested that female sex, larger size of the skin prick test and higher *Ara h 2*-specific IgE level were all significantly associated with a lower threshold dose. The associations seen are large but this is modelling at a population level. Precisely can we predict thresholds in individuals?

Victor *et al*⁸ have looked at the level of horse allergens in dander saliva and urine from ten different breeds. They chose to focus on *Equ c 4* as most individuals with horse allergy are sensitized to this component. *Equ c 4* was found in all dander and saliva samples almost all urine samples (Figure 1). There was considerable variability between individual animals but no significant differences between breeds. Levels were significantly higher in stallions than mares and geldings. So unfortunately, there does not seem to be a “hypoallergenic” horse.

We all know that the approach to clinical care will need to change within the NHS. Clinical demand is increasing more rapidly than monies allocated to health in the UK, like other countries. We need to change the way we deliver allergy care to minimize costs while maintaining the standard of care. In this issue of the Journal, El-Shanawany *et al*⁹ describe a community allergy clinic, run by a general practitioner with an extended role that seems to have succeeded in delivering care closer to patients. Drs Jay and Angier comment on their approach in a related editorial.¹⁰

Finally, you may be interested in a systematic review that has just been published in the Lancet. Chu *et al* take a very different approach in their meta-analysis of oral immunotherapy for peanut

allergy. Their analysis raises some very interesting questions which I have highlighted in an accompanying editorial in the Lancet.

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