The role of corticosteroids in bronchiolitis and croup

Anthony D Milner

The introduction of systemic and inhaled topical corticosteroids may not have significantly reduced mortality from childhood asthma, but it has greatly improved the quality of life for many children and now they have an important and well-established role in asthma management. Over the years corticosteroids have also been considered as possible treatment for two other forms of airway obstruction – acute laryngobronchitis (or croup) and acute bronchiolitis.

The effects of corticosteroids on croup have been so dramatic and well documented that the only surprise is that this form of treatment has taken so long to be generally accepted. In 1980 a critical assessment of nine studies on the efficacy of systemic corticosteroids was published. Most were considered to have unsatisfactory clinical designs and it was concluded that the role of corticosteroids in the treatment of croup was unproven. The turning point came in 1989 with the publication by Kairys and colleagues of a meta-analysis of nine placebo controlled trials considered to be satisfactory. Of these, only two of seven showed a significant advantage for systemic corticosteroids after 12 hours of treatment and two of four at 24 hours. One of the four studies in which children required intubation showed significant protection. Although most of the studies failed to show significant effects, in all the studies there was a trend in favour of corticosteroids so that the meta-analysis demonstrated a positive effect. The authors claimed that their data supported the use of steroids in infants ill enough to be admitted to hospital. This led to renewed interest in this area.

At one extreme of severity, oral prednisolone has been shown by the Perth group to reduce the time to extubation from a mean of 138 hours to 98 hours, and also the need for reintubation. A further study found that a relatively small dose of dexamethasone, 0.15 mg/kg, was as effective as 0.6 mg/kg in relieving symptoms and reducing the time to discharge. Others have compared the effects of corticosteroids with nebulised adrenaline and there are now two randomised studies on the outpatient use of oral corticosteroids, one showing that treatment reduces the need for reintubation at the emergency department and the other indicating a more rapid resolution in respiratory symptoms.

There has also been increasing interest in the role of inhaled nebulised budesonide in the treatment of croup. Three placebo controlled trials have been published, all of which showed more rapid resolution in symptoms, and two reported a reduction in time to discharge. One study has compared nebulised budesonide with oral dexamethasone in a dose of 0.6 mg/kg. Both treatments were superior to placebo with non-significant trends in favour of dexamethasone. A further publication in which all the children received oral corticosteroids and were then randomised to receive either budesonide or placebo inhalations showed a reduction in symptoms after four hours in the treatment group but no difference in hospital admission rates.

These studies confirm that both systemic steroids and nebulised budesonide are effective therapies. As stated recently by Thomson, croup is usually benign and self-limiting so that treatment should be reserved for those with stridor and recession at rest. Oral corticosteroids would appear to be preferable as administration is less invasive in a distressed young child and budesonide at £4.46 for 2 mg is approximately 100 times more expensive than oral dexamethasone.

For acute bronchiolitis, which is caused by respiratory syncytial virus (RSV), it is well established that the disease involves an acute inflammatory process with massive invasion of the respiratory tract by neutrophils. It is also generally accepted that bronchiolitis is associated with a risk factor of 3–4 for subsequent asthma symptoms, although it remains contentious whether the bronchiolitis itself is responsible or whether those at increased risk for developing severe bronchiolitis, either from a genetic atopy tendency or subnormal neonatal lung function, are selectively admitted to hospital. Whatever the mechanism, bronchiolitis would appear to be a condition that is likely to be modified by corticosteroid therapy. It has always been something of a surprise that in the past, with one exception, no double blind controlled study has shown measurable benefit. The initial positive study published by Oski and colleagues in abstract form was relatively small, involving only 20 infants. Of these, nine received dexamethasone and 11 placebo. The results, however, were quite striking with a significant reduction in the time on oxygen (25 versus 44 hours) and more rapid discharge from hospital (4.4 versus 7.0 days). Subsequent studies with larger numbers of infants – for example, Sussman et al (49 infants), Dabbous et al (44 infants), Connolly et al (95 infants), and the large study by Leer et al (297) – all failed to show that systemic corticosteroids had any effect on the natural history of acute bronchiolitis. Even Oski et al were unable to confirm their initial findings in a subsequent larger study. As a result of these publications, the Committee on Drugs for the American Academy of Pediatrics concluded in 1970 that “there is no scientific basis for the routine administration of corticosteroids in bronchiolitis.”

Perhaps because of this statement, there were relatively few studies in the next 20 years and the consensus remained that systemic steroids had little to offer in the management of bronchiolitis. One study on the effects of steroids and β2 agonists on the symptoms of 32 wheezy infants, some of whom (number not stated) had bronchiolitis, suggested that neither form of treatment had any effect on the rate of resolution of symptoms but that the combination was useful. The design of the study was relatively complicated with only eight infants in each treatment cell. Subsequent studies by De Boece et al and Springer et al (50 infants) were also negative. Perhaps the strongest statement against the use of systemic steroids has been provided by a study from Chicago published in the Lancet last year. This group recruited 118 infants under the age of 12 months who required admission to hospital for acute bronchiolitis. Sixty five received intramuscular dexamethasone (1 mg/kg daily for up to three days) and 53 were given saline injections as placebo. They were unable to show any effects of steroid therapy on the rate of resolution of symptoms, time in oxygen, or the incidence of respiratory symptoms in the 10–14 days after discharge.

In total contrast, in this issue of Thorax van Woensel et al report the results of a well designed study into the effects of oral prednisolone on respiratory symptoms in...
almost uniquely positive because others have either failed
Department of Paediatrics,
university experience16 and that of others15
requirement was that all should be RSV positive on1 Tunnessen W, Feinstein A. The steroid-croup controversy: an analytic
Bronchitis), corticosteroids given systemically or by inhalation
are useful in the management of those children who
for other double blind studies which have failed to show any
Thus it appears that, in the case of croup (acute laryngo-
other double blind studies which have failed to show any
Inhaled corticosteroids are help-
for post-bronchiolitic asthma symp-
tom but further positive studies are needed before
prophylactic courses can be recommended for use im-
after acute bronchiolitis.

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1 Tunnessen W, Feinstein A. The steroid-croup controversy: an analytic
2 Kairys SW, O'Brien EM, O'Connor GT. Steroid treatment of laryngo-
21 Connolly JE, Field CMB, Glasgow JT, Slater CM, MacLennan DM. A double blind trial of dexamethasone in epidemic bronchiolitis due to res-
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