

with regular oral corticosteroids in a child with few symptoms. However, the fact remains the principle of sputum based inflammation monitoring has not been tested by this study,³ yet the paper is being presented as a test of that process. In this respect, the manuscript is similar to that of Szeffler *et al*⁴ where a serious design limitation also prevented optimal assessment of the technique.^{2 5}

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Authors' response

We thank Fleming and Bush for their comments¹ on our editorial². We accept that there is no good evidence of a dose-response relationship against eosinophilic airway inflammation with higher dose inhaled steroids in children with asthma. We also recognise that it might be difficult to justify high dose inhaled corticosteroids, or treatment