subjects there was an increase in bronchial hyperresponsiveness only during the first two weeks of the study, but by the end of four weeks this increase had disappeared. In the study of Vathenen et al (ref 7) with eight asthmatic subjects it was observed that a (rebound) increase in hyperresponsiveness occurred, not whilst using the β agonist but afterwards. In our own study (ref 14) an increase in hyperresponsiveness was observed when using a β agonist in a selected group of 15 patients. These 15 patients were selected on the condition that they had not used any β agonists or β blockers for one year before the start of the study. They were part of a much larger group of 144 patients who, on average, did not show an increase in bronchial hyperresponsiveness during the continuous use of a bronchodilator.

This underlines our conclusion that only in subgroups of patients who might the continuous use of a β adrenergic drug have an adverse effect on bronchial hyperresponsiveness. The only exception seems to be the study of Sears and Taylor themselves (ref 3) with a relatively large number of 64 patients. However, this is the only study in which patients were allowed to use anti-inflammato- 
y drugs as well as their bronchodilator drugs.

As Sears and Taylor have already acknowledged, the observed changes in hyper- 
responsiveness seem small. They found all between 0.5 and 1.5 doubling doses of the challenge test, which is virtually similar to the repeatability of the challenge test and is therefore of doubtful clinical significance.

The purpose of writing our editorial was not to present a neutral position in this important issue but to show that the general fear that exists among doctors and patients about the chronic use of bronchodilators does not have to be justified by the data available at this moment. We did not, and not, doubt that bronchodilators probably have a (small) negative influence on the long term prognosis of bronchial hyperresponsiveness in certain groups of asthmatic patients. Subgroup analyses of our own data have shown that especially allergic hyper- 
asthmatic patients seem to have an increased progression of asthma with con- 
tinuous use of a β agonist.1 Another important issue which still has to be settled is what additional bronchodilator drug should be used (in what dose) when the patient receives a combination of an anti-inflammato- 
y drug and a bronchodilator.

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Extrapulmonary effects of fenoterol and salbutamol in normal subjects

Newnham et al have attempted the difficult task of trying to dissect relative β1 and β2 mediated cardiovascular responses to large doses of salbutamol and fenoterol in normal subjects with a low dose of atenolol (June 1993;48:656–8). There are two issues: firstly, the comparative responses to similar doses of these agents by inhalation and, secondly, their selectivity at the β2 receptor.

Newnham et al showed that salbutamol and fenoterol in doses of 1 mg and 3 mg from metered dose inhalers led to similar increases in heart rate, stroke distance, and tremor, with fenoterol causing a slightly larger fall in serum potassium concentration and a greater rise in systolic blood pressure than salbutamol. Their findings suggest smaller differences between higher doses of salbutamol and fenoterol having larger effects than other studies, whether the comparisons have been made in vitro, in vivo, or in different species.12 Invariably fenoterol has been found to be more potent in large doses than salbutamol, and this was confirmed in the present study which had preparations available that showed a 2–4 times greater effect on heart rate with fenoterol, and this has led to a tenfold difference in the concentra- 

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AUTHORS' REPLY In reply to the letter of 
Crane et al there are some fundamental issues which were discussed in the paper, require further clarification.

The purpose of our study was not to assess 

the relative potency of fenoterol and salbuta- 

mol, which requires comparison of 
histamine to asthmatic subjects to ascertain relative bron- 
chodilator and systemic β2 receptor activity. The 25 mg dose of atenolol in our study was chosen on the basis of it producing relatively selective β2 blockade. It is, however, well documented that atenolol displays dose related β blockade,13 and so it is not, per- 
haps, surprising that even a 25 mg dose produced a degree of β2 antagonism. The impor- 
tant point is that a comparable degree of attenuation occurred with heart rate and 
potassium responses, both of which have been shown to be β2 mediated.14 Indeed, this 
occurred to the same extent with both feno- 
terol and salbutamol.

If fenoterol had stimulated cardiac β2 receptors to a greater degree than salbuta- 

mol, one would have predicted atenolol to have antagonised the chronotropic response to fenoterol more than salbutamol. This was clearly not the case with the percentage attenuation by atenolol at the 4 mg dose being 14% for fenoterol and 16% for salbu- 
tamol. The percentage attenuation of the systolic blood pressure was also comparable for these doses of salbutamol (10%) and fenoterol (8%). Thus, whilst fenoterol may exhibit greater β2 potency, there is no evidence for it being less selective in terms of relative car- 
diac β1/β2 receptor stimulation. It is also 

worth pointing out that in a study from Windom et al15 in asthmatic subjects there 
was no difference in either chronotropic or systolic blood pressure responses to fenoterol and salbutamol, in contrast with isoprenaline which produced greater effects, presumably β2 adrenoceptor mediated.

In our view data are indeed supported by 

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