Back to the drawing board

As a physician with an interest in asthma, I read the article[1] on leukotriene receptor antagonists (LTRAs) with great interest; however, after reading it, I was thoroughly confused.

First, it would have been interesting to know who, in fact, put this article together. Was it a compilation or was it one author? I would address my questions to the author directly if I could. I believe the article did a great disservice to this class of medications. Within my practice, this medication has revolutionized the treatment and management of asthma. The Canadian guidelines published recently,[2] which every Canadian family physician received, conflict directly with this article, and I believe the Canadian guidelines, at least the summary statement or chart, should have been published with it to show where montelukast and drugs of this class should be placed. I also noticed you made note of the price for only the 5-mg tablet and not the 10-mg tablet.

The article contains many examples of poor translation (I assume this article was translated from French to English). The indications shown are very much European, not Canadian. The Canadian indications clearly state that these are excellent additive therapies or therapies that can be used alone, or with as needed, β_2-agonists for people who cannot or will not take inhaled steroids. People taking inhaled β_2-agonists more than two to three times a week regularly should receive some form of maintenance therapy. Montelukast is indeed indicated for preventing asthma and asthma symptoms in children 6 years and older, and has indeed been cleared for use in those who are acetylsalicylic acid-sensitive and in people who have exercise-induced asthma.

In fact, a number of studies show that montelukast is effective either on its own or in combination with other agents. Leukotriene inhibitors enable physicians to reduce the amount of inhaled corticosteroids prescribed to patients.

The article seems to emphasize the use of oral β_2 stimulants, short-acting β_2-agonists, and theophyllines. These agents are not used comparably in managing asthma in Canada. In studies of all the LTRAs and even the long-acting β_2-agonists, reducing use of short-term β_2-agonists is the major indicator of quality of control or adequacy of control. Numerous studies worldwide compare LTRAs with inhaled corticosteroids, the cromoglycate group, and long-acting β_2-agonists.

In 25 years of treating asthma, I have been fortunate not to see any cases of Churg-Strauss syndrome, but those cases that have occurred can happen with all classes of anti-inflammatory agents, not just with montelukast.

Something has been lost in translation here, and this is most disappointing, given the nature of *Canadian Family Physician*. I must condemn the editorial staff for not doing their homework on this article. I think you have done a great disservice to those of us who have an interest in and an obligation to treat asthma. These agents and others have allowed us to offer patients alternative treatments that otherwise would not be available. The role of these agents has been clearly defined in the latest consensus guidelines. An apology or at least some kind of amendment must be published. The translation of the original French article, which I was able to obtain, should read "Montelukast. Role in asthma remains to be determined" and not "Montelukast. No demonstrated role in the management of asthma."

Finally, whoever wrote this article needs to go back to the drawing board! As an interested physician, I would appreciate the autahors' feedback or any other expert's feedback on this article.

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References

1. Prescrire. Evidence-based drug reviews. Montelukast. No current use for asthma [Prescrire]. *Can Fam Physician* 2000;46:85-91 (Eng), 92-9 (Fr).
2. Boulet L-P, Becker A, Bérubé D, Beveridge R, Ernst P, on behalf of the Canadian Asthma Consensus Group. Summary of recommendations from the Canadian Asthma Consensus Report, 1999. *Can Med Assoc J* 1999;161(11 Suppl):S1-S12.