

It is important to remember that both trials were done by the same investigators and the only study that showed a statistical benefit was an open-label trial. Of interest, a double-blind trial in which the dose of inhaled corticosteroid was quintupled showed no effect on clinical outcomes in children aged 5 to 11 years with mild to moderate asthma.⁵

Given the above, I would disagree this would be considered an adequate evidence base to justify a *carte blanche* recommendation of quadrupling the dose of inhaled corticosteroids. In fact, the authors of the 2 studies state that “a group of local general practitioners, asthma nurses, and asthma experts suggested that a reduction of one third in the number of people initiating a course of systemic glucocorticoids is a worthwhile treatment effect,” yet in their trial they reported only a relative reduction in exacerbations of 19%.³ They also state “guideline committees will need to consider whether the magnitude of the reduction achieved is clinically meaningful.”³

A true evidence-based tool would include the concept of shared decision making and so, at a minimum, patients should be told that adopting a quadrupling of inhaled corticosteroids action plan will lead to an NNT of 14 (about a 7% absolute difference) for not having to start oral corticosteroids. But to achieve that NNT, a number of people (depending on the baseline exacerbation rate) will have to receive doses of inhaled corticosteroids for 7 to 14 days that would be systemically about half (10 to 20 mg) of what would be used for an exacerbation (Osborne et al used 30 mg of oral prednisone for exacerbations²). In addition, for those who quadruple the dose there is a number needed to harm of about 20 (a 5% absolute increase) primarily for candidiasis and dysphonia, and there is an additional inhaler cost and inconvenience to this action plan. Given this information, some might choose this option while others might just want a discussion of what to look out for with regard to exacerbations and when to seek medical help.

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Competing interests

None declared

References

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Value of monkey bars?

As an 8-year-old I fell from monkey bars that were 8 feet tall (I was half that height), with my elbow striking a rock conveniently placed beneath them. I had a complex fracture that led to external fixation and a lifelong gunstock deformity but no other sequelae. I spent 3 weeks in traction, during which time I read the *Golden Book Encyclopedia* from A to Z, much to my doctor's amazement. I am now an academic family physician, and a dual Canadian-American national, and can twist my left arm in ways that both amaze and disgust my younger relatives.

Of course, play cannot and should not be without risk. But reasonable bounds should be put in place to mitigate the risk of serious injury (ie, assuring age-appropriate heights for falls, removing rocks, and eliminating equipment that could lead to rare but catastrophic spinal injuries). The authors of the rapid systematic review on playground injuries in the March issue of *Canadian Family Physician* appear to minimize the suffering of 1500 hospitalized children per year in Canada alone, and fail to cite high-quality evidence that risky play provides greater social and intellectual benefits than less risky or safe play.¹

Bad things happen rarely. But just because your child is fortunate enough to go through childhood unharmed despite a *laissez-faire* attitude, it does not mean you should broadly advocate for it without better evidence that the small potential benefits for all outweigh the rare but severe harms to the few.

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Competing interests

None declared

Reference

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Link between dietary changes and tinnitus management

I congratulate Dr Wu and colleagues for their very good and practical clinical review of tinnitus management in the July 2018 issue of *Canadian Family Physician*.¹ As part of conservative management, the authors also recommend reducing caffeine consumption.¹ As a nutrition scientist, I am surprised because there is no supporting empirical scientific evidence for the commonly advocated restriction of caffeine for tinnitus patients.²

Dietary changes are also named as a management strategy in the case resolution of the article.¹ However, there was still no well-founded review on the nutritional modifications that are repeatedly discussed among patients as well as doctors. I would like to point out the following: In the March 2019 issue of the *Australian Journal of General Practice*, my article titled “Do dietary factors significantly influence tinnitus?” was published.² It would be desirable for family physicians and *Canadian*