

POLICY & PRACTICE

Virginia Children Wait for Medicaid

More than half of Virginia children whose parents applied for Medicaid coverage waited for 4-6 months for their applications to be processed—and 90% went without coverage during that time—as a result of a new federal law requiring proof of citizenship to receive benefits, according to a state survey. The survey of 800 families, conducted by the Virginia Health Care Foundation in partnership with the Virginia Department of Medical Assistance Services, found that the new requirements resulted in a significant decrease

in the number of children enrolled in Medicaid in the state, in an inability of citizen children to obtain medical care, and in a dramatic increase in emergency department utilization by those caught up in lengthy eligibility determinations.

Report Disputes SCHIP Numbers

An Urban Institute analysis of uninsured children eligible for the State Children's Health Insurance Program (SCHIP) indicates that far fewer children than previously thought may be eligible for SCHIP. The new study focuses on children who

were uninsured for an entire year, unlike other studies that have looked at children who were uninsured for just part of a year. The Health and Human Services Department, which released the new Urban Institute study, said the lower estimate shows that adding \$50 billion in additional funding to the SCHIP program is unnecessary. But Democratic senators, who are slated to consider SCHIP reauthorization legislation soon, dismissed the report.

MDs Should Use the Term 'Obese'

Physicians should use blunt, clinical terms such as "overweight" and "obese" to describe conditions currently called "at risk

for overweight" and "overweight," a panel of health experts representing 15 major medical associations said in a report. In recommending the changes, the panel members said that the terms used now allow physicians to avoid counseling patients in need of intervention. The panel also recommended that physicians assess children's weight and body mass index at least once a year and evaluate nutrition and activity habits for all pediatric patients during regular checkups. The panel was convened by the American Medical Association, with funding from federal agencies, and the voluntary guidelines have been endorsed by the American Academy of Pediatrics.

Pulmicort 90 & Flexhaler 180 mcg

(budesonide inhalation powder, 90 mcg & 180 mcg)

For Oral Inhalation Only.

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PROFESSIONAL INFORMATION BROCHURE)

INDICATIONS AND USAGE PULMICORT FLEXHALER is indicated for the maintenance treatment of asthma as prophylactic therapy in adult and pediatric patients six years of age or older. It is also indicated for patients requiring oral corticosteroid therapy for asthma. Many of these patients may be able to reduce or eliminate their requirement for oral corticosteroids over time. PULMICORT FLEXHALER is NOT indicated for the relief of acute bronchospasm. **CONTRAINDICATIONS** PULMICORT FLEXHALER is contraindicated in the primary treatment of status asthmaticus or other acute episodes of asthma where intensive measures are required. PULMICORT FLEXHALER is contraindicated in patients with known hypersensitivity to any component of the formulation.

WARNINGS Particular care is needed for patients who are transferred from systemically active corticosteroids to PULMICORT FLEXHALER because deaths due to adrenal insufficiency have occurred in asthmatic patients during and after transfer from systemic corticosteroids to less systemically available inhaled corticosteroids. After withdrawal from systemic corticosteroids, a number of months are required for recovery of HPA function. Patients who have been previously maintained on 20 mg or more per day of prednisone (or its equivalent) may be most susceptible, particularly when their systemic corticosteroids have been almost completely withdrawn. During this period of HPA suppression, patients may exhibit signs and symptoms of adrenal insufficiency when exposed to trauma, surgery, or infection (particularly gastroenteritis) or other conditions associated with severe electrolyte loss. Although PULMICORT FLEXHALER may provide control of asthma symptoms during these episodes, in recommended doses it supplies less than normal physiological amounts of glucocorticoid systemically and does NOT provide the mineralocorticoid activity that is necessary for coping with these emergencies. During periods of stress or a severe asthma attack, patients who have been withdrawn from systemic corticosteroids should be instructed to resume oral corticosteroids (in large doses) immediately and to contact their physicians for further instruction. These patients should also be instructed to carry a medical identification card indicating that they may need supplementary systemic corticosteroids during periods of stress or a severe asthma attack. Patients requiring oral corticosteroids should be warned slowly from systemic corticosteroid use after transferring to PULMICORT FLEXHALER. Lung function (FEV₁ or AM PEF), beta-agonist use, and asthma symptoms should be carefully monitored during withdrawal of oral corticosteroids. In addition to monitoring asthma signs and symptoms, patients should be observed for signs and symptoms of adrenal insufficiency such as fatigue, lassitude, weakness, nausea and vomiting, and hypotension. Transfer of patients from systemic corticosteroid therapy to PULMICORT FLEXHALER may unmask allergic conditions previously suppressed by the systemic corticosteroid therapy, eg, rhinitis, conjunctivitis, arthritis, eosinophilic conditions, and eczema (see DOSAGE AND ADMINISTRATION in Full Prescribing Information). Patients who are on drugs which suppress the immune system are more susceptible to infection than healthy individuals. Chicken pox and measles, for example, can have a more serious or even fatal course in susceptible pediatric patients or adults on immunosuppressant doses of corticosteroids. In pediatric or adult patients who have not had these diseases, particular care should be taken to avoid exposure. How the dose, route, and duration of corticosteroid administration affects the risk of developing a disseminated infection is not known. The contribution of the underlying disease and/or prior corticosteroid treatment to the risk is also not known. If exposed, therapy with varicella zoster immune globulin (VZIG) or pooled intravenous immunoglobulin (IVIg), as appropriate, may be indicated. If exposed to measles, prophylaxis with pooled intramuscular immunoglobulin (IG) may be indicated. (See the respective package inserts for complete VZIG and IG prescribing information.) If chicken pox develops, treatment with antiviral agents may be considered. PULMICORT FLEXHALER is not a bronchodilator and is not indicated for rapid relief of bronchospasm or other acute episodes of asthma. As with other inhaled asthma medications, bronchospasm, with an immediate increase in wheezing, may occur after dosing. If bronchospasm occurs following dosing with PULMICORT FLEXHALER, it should be treated immediately with a fast-acting inhaled bronchodilator. Treatment with PULMICORT FLEXHALER should be discontinued and alternate therapy instituted. Patients should be instructed to contact their physician immediately when episodes of asthma not responsive to their usual doses of bronchodilators occur during treatment with PULMICORT FLEXHALER. During such episodes, patients may require therapy with oral corticosteroids. **PRECAUTIONS** General: During withdrawal from oral corticosteroids, some patients may experience symptoms of systemically active corticosteroid withdrawal, eg, joint and/or muscular pain, lassitude, and depression, despite maintenance or even improvement of respiratory function (see DOSAGE AND ADMINISTRATION). In responsive patients, PULMICORT FLEXHALER may permit control of asthma symptoms with less suppression of HPA-axis function than therapeutically equivalent oral doses of prednisone. Since budesonide is absorbed into the circulation and can be systemically active, the beneficial effects of PULMICORT FLEXHALER in minimizing HPA dysfunction may be expected only when recommended dosages are not exceeded and individual patients are titrated to the lowest effective dose. Since individual sensitivity to effects on cortisol production exists, physicians should consider this information when prescribing PULMICORT FLEXHALER. Because of the possibility of systemic absorption of inhaled corticosteroids, patients treated with PULMICORT FLEXHALER should be observed carefully for any evidence of systemic corticosteroid effects. Particular care should be taken in observing patients postoperatively or during periods of stress for evidence of inadequate adrenal response. It is possible that systemic corticosteroid effects such as hypercorticism, reduced bone mineral density, and adrenal suppression may appear in a small number of patients, particularly at higher doses. If such changes occur, PULMICORT FLEXHALER should be reduced slowly, consistent with accepted procedures for management of asthma symptoms and for tapering of systemic steroids. Orally inhaled corticosteroids, including budesonide, may cause a reduction in growth velocity when administered to pediatric patients. A reduction in growth velocity may occur as a result of inadequate control of asthma or from use of corticosteroids for treatment. The potential effects of prolonged treatment on growth velocity should be weighed against the clinical benefits obtained and the risks associated with alternative therapies. To minimize the systemic effects of orally inhaled corticosteroids, including PULMICORT FLEXHALER, each patient should be titrated to his/her lowest effective dose (see PRECAUTIONS, Pediatric Use). Although patients in clinical trials have received inhaled budesonide on a continuous basis for periods of 1 to 2 years, the long-term local and systemic effects of PULMICORT FLEXHALER in human subjects are not completely known. In particular, the effects resulting from chronic use of PULMICORT FLEXHALER on developmental or immunological processes in the mouth, pharynx, trachea, and lung are unknown. In clinical trials with PULMICORT FLEXHALER, localized infections with *Candida albicans* occurred in the mouth and pharynx in some patients. These infections may require treatment with appropriate antifungal therapy and/or discontinuance of treatment with PULMICORT FLEXHALER. Inhaled corticosteroids should be used with caution, if at all, in patients with active or quiescent tuberculous infection of the respiratory tract, untreated systemic fungal, bacterial, viral, or parasitic infections, or ocular herpes simplex. Rare instances of glaucoma, increased intraocular pressure, and cataracts have been reported following the inhaled administration of corticosteroids. **Information for Patients** Patients being treated with PULMICORT FLEXHALER should receive the following information and instructions. This information is intended to aid the patient in the safe and effective use of the medication. It is not a disclosure of all possible adverse or intended effects. For proper use of PULMICORT FLEXHALER and to attain maximum improvement, the patient should read and follow the accompanying Patient's Instructions for Use. • Patients should use PULMICORT FLEXHALER at regular intervals as directed since its effectiveness depends on regular use. The patient should not alter the prescribed dosage unless advised to do so by the physician. • Patients should be advised that PULMICORT FLEXHALER is not a bronchodilator and is not intended to treat acute or life-threatening episodes of asthma. • Patients should be advised that the effectiveness of PULMICORT FLEXHALER depends on proper use of the device and inhalation-administering technique: ○ 1) PULMICORT FLEXHALER must be in the upright position (mouthpiece on top) during loading in order to provide the correct dose. ○ 2) PULMICORT FLEXHALER must be primed when the unit is used for the very first time. To prime the unit, it must be held in an upright position and the brown grip turned fully in one direction as far as it will go, then twisted fully back again in the other direction as far as it will go. One of the twisting movements will produce an audible click. This procedure must be repeated. ○ 3) To load the first dose, the grip must be turned fully in one direction and then fully in the other direction until it clicks. ○ 4) After the first dose, it is not necessary to prime the unit. However, it must be loaded in the

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upright position immediately prior to use as described above. ○ 5) Patients should be advised not to shake the inhaler. • Patients should place the mouthpiece between the lips and inhale forcefully and deeply. The powder is then delivered to the lungs. • Patients should not exhale through PULMICORT FLEXHALER. • Due to the small volume of powder, patients may not sense the presence of any medication entering the lungs when inhaling from PULMICORT FLEXHALER. This lack of sensation does not indicate that the patient is not receiving benefit from PULMICORT FLEXHALER. • Patients should be advised that rinsing the mouth with water without swallowing after each dosing may decrease the risk of the development of oral candidiasis. • Patients should be instructed that they will receive a new PULMICORT FLEXHALER unit each time they refill their prescription. Patients should be advised to discard the whole device after the labeled number of inhalations has been used. The dose indicator window tells how many doses are left in the inhaler. The inhaler is empty when the number zero ("0") on the red background reaches the middle of the window. • PULMICORT FLEXHALER should not be used with a spacer. • The mouthpiece should not be bitten or chewed. • Replace the cover securely after each opening. • Patients should keep PULMICORT FLEXHALER clean and dry at all times. • Patients should be advised that improvement in asthma control following inhalation of budesonide can occur within 24 hours of beginning treatment although maximum benefit may not be achieved for 1 to 2 weeks, or longer. If symptoms do not improve in that time frame, or if the condition worsens, the patient should be instructed not to increase the dosage, but to contact the physician. • Patients whose systemic corticosteroids have been reduced or withdrawn should be instructed to carry a warning card indicating that they may need supplemental systemic corticosteroids during periods of stress or an asthma attack that does not respond to bronchodilators. • Patients should be advised not to stop the use of PULMICORT FLEXHALER abruptly. • Patients should be warned to avoid exposure to chicken pox or measles and if they are exposed, to consult their physicians without delay. • Long-term use of inhaled corticosteroids, including budesonide, may increase the risk of some eye problems (cataracts or glaucoma). Regular eye examinations should be considered. • Women considering the use of PULMICORT FLEXHALER should consult with their physician if they are pregnant or intend to become pregnant, or if they are breast-feeding a baby. • Patients considering use of PULMICORT FLEXHALER should consult with their physician if they are allergic to budesonide or any other orally inhaled corticosteroid. • Patients should inform their physician of other medications they are taking as PULMICORT FLEXHALER may not be suitable in some circumstances and the physician may wish to use a different medicine. **Drug Interactions:** In clinical studies, concurrent administration of budesonide and other drugs commonly used in the treatment of asthma has not resulted in an increased frequency of adverse events. The main route of metabolism of budesonide, as well as other corticosteroids, is via cytochrome P450 (CYP) isoenzyme 3A4 (CYP3A4). After oral administration of ketoconazole, a potent inhibitor of CYP3A4, the mean plasma concentration of orally administered budesonide increased. Concomitant administration of other known inhibitors of CYP3A4 (eg, itraconazole, clarithromycin, erythromycin, etc.) may inhibit the metabolism of, and increase the systemic exposure to, budesonide. Care should be exercised when budesonide is administered with long-term ketoconazole and other known CYP3A4 inhibitors. **Carcinogenesis, Mutagenesis, Impairment of Fertility:** Long-term studies were conducted in rats and mice using oral administration to evaluate the carcinogenic potential of budesonide. In a 104-week oral study in Sprague-Dawley rats, a statistically significant increase in the incidence of gliomas was observed in male rats receiving an oral dose of 50 mg/kg/day (less than the maximum recommended daily inhalation dose in adults and children on a mcg/m² basis). No tumorigenicity was seen in male and female rats at respective oral doses up to 25 and 50 mg/kg (less than the maximum recommended daily inhalation dose in adults and children on a mcg/m² basis). In two additional two-year studies in male Fischer and Sprague-Dawley rats, budesonide caused no gliomas at an oral dose of 50 mg/kg (less than the maximum recommended daily inhalation dose in adults and children on a mcg/m² basis). However, in the male Sprague-Dawley rats, budesonide caused a statistically significant increase in the incidence of hepatocellular tumors at an oral dose of 50 mg/kg (less than the maximum recommended daily inhalation dose in adults and children on a mcg/m² basis). The concurrent reference corticosteroids (prednisone and triamcinolone acetonide) in these two studies showed similar findings. There was no evidence of a carcinogenic effect when budesonide was administered orally to 91-week-old mice at doses up to 200 mg/kg/day (less than the maximum recommended daily inhalation dose in adults and children on a mcg/m² basis). Budesonide was not mutagenic or clastogenic in six different test systems: Ames Salmella/microsome plate test, mouse micronucleus test, mouse lymphoma test, chromosome aberration test in human lymphocytes, sex-linked recessive lethal test in *Drosophila melanogaster*, and DNA repair analysis in rat hepatocyte culture. In rats, budesonide had no effect on fertility at subcutaneous doses up to 80 mg/kg (less than the maximum recommended human daily inhalation dose on a mcg/m² basis). At 20 mg/kg/day (less than the maximum recommended human daily inhalation dose on a mcg/m² basis), decreases in maternal body weight gain, prenatally viability, and viability of the young at birth and during lactation were observed. No such effects were noted at 5 mg/kg (less than the maximum recommended human daily inhalation dose in adults on a mcg/m² basis). **Pregnancy:** Teratogenic Effects: Pregnancy Category B As with other glucocorticoids, budesonide produced fetal loss, decreased pup weight, and skeletal abnormalities at subcutaneous doses of 25 mg/kg/day in rabbits (less than the maximum recommended human daily inhalation dose on a mcg/m² basis) and 500 mg/kg/day in rats (approximately 3 times the maximum recommended human daily inhalation dose on a mcg/m² basis). No teratogenic or embryofetal effects were observed in rats when budesonide was administered by inhalation at doses up to 250 mg/kg/day (equivalent to the maximum recommended human daily inhalation dose on a mcg/m² basis). Experience with oral corticosteroids since their introduction in pharmacologic use as opposed to physiologic doses suggests that rodents are more prone to teratogenic effects from corticosteroids than humans. Studies of pregnant women, however, have not shown that inhaled budesonide increases the risk of abnormalities when administered during pregnancy. The results from a large population-based prospective cohort epidemiological study reviewing data from three Swedish registries covering approximately 99% of the pregnancies from 1995-1997 (i.e., Swedish Medical Birth Registry; Registry of Congenital Malformations; Child Cardiology Registry) indicate no increased risk for congenital malformations from the use of inhaled budesonide during early pregnancy. Congenital malformations were studied in 2,014 infants born to mothers reporting the use of inhaled budesonide for asthma in early pregnancy (usually 10-12 weeks after the last menstrual period), the period when most major organ malformations occur. The rate of recorded congenital malformations was similar compared with the general population rate (3.8% vs. 3.5%, respectively). In addition, after exposure to inhaled budesonide, the number of infants born with orofacial clefts was similar to the expected number in the normal population (4 children vs. 3.3, respectively). These same data were utilized in a second study bringing the total to 2,334 infants whose mothers were exposed to inhaled budesonide. In this study, the rate of congenital malformations among infants whose mothers were exposed to inhaled budesonide during early pregnancy was not different from the rate for all newborn babies during the same period (3.6%). Despite the animal findings, it would appear that the possibility of fetal harm is remote if the drug is used during pregnancy. Nevertheless, because the studies in humans cannot rule out the possibility of harm, PULMICORT FLEXHALER should be used during pregnancy only if clearly needed. **Nonteratogenic Effects:** Hypoadrenalism may occur in infants born of mothers receiving corticosteroids during pregnancy. Such infants should be carefully observed. **Nursing Mothers:** Corticosteroids are secreted in human milk. Because of the potential for adverse reactions in nursing infants from any corticosteroid, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the importance of the drug to the mother. Actual data for budesonide are lacking. **Pediatric Use:** Safety and effectiveness of PULMICORT FLEXHALER in pediatric patients below 6 years of age have not been established. Clinical studies with inhaled budesonide included 704 patients 6 to 17 years of age (n=204 treated with PULMICORT FLEXHALER). The frequency of adverse events observed with PULMICORT FLEXHALER in pediatric patients 6 to 17 years of age was similar to that of patients 18 to 80 years of age. Controlled clinical studies have shown that orally inhaled corticosteroids may cause a reduction in growth velocity in pediatric patients. This effect has been observed in the absence of laboratory evidence of hypothalamic-pituitary-adrenal (HPA) axis suppression, suggesting that growth velocity is a more sensitive indicator of systemic corticosteroid exposure in pediatric patients than some commonly used tests of HPA-axis function. The long-term effects of this reduction in growth velocity associated with orally inhaled corticosteroids including the impact on final adult height are unknown. The potential for "catch up" growth following discontinuation of treatment with orally inhaled corticosteroids has not been adequately studied. In a study of asthmatic children 5-12 years of age, those treated with PULMICORT TURBUHALER 200 mcg twice daily (n=311) had a 1.1-centimeter reduction in growth compared with those receiving placebo (n=418) at the end of one year; the difference between these two treatment groups did not increase further over three years of additional treatment. By the end of four years, children treated with PULMICORT TURBUHALER and children treated with placebo had similar growth velocities. Conclusions drawn from this study may be confounded by the unequal use of corticosteroids in the treatment groups and inclusion of data from patients attaining puberty during the course of the study. The growth of pediatric patients receiving

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orally inhaled corticosteroids, including PULMICORT FLEXHALER, should be monitored routinely (eg, via stadiometry). The potential growth effects of prolonged treatment should be weighed against clinical benefits obtained and the risks and benefits associated with alternative therapies. To minimize the systemic effects of inhaled corticosteroids, including PULMICORT FLEXHALER, each patient should be titrated to his/her lowest effective dose. **Geriatric Use:** Of the total number of patients in controlled clinical studies receiving inhaled budesonide, 153 (n=11 treated with PULMICORT FLEXHALER) were 65 years of age or older and one was age 75 years or older. No overall differences in safety were observed between these patients and younger patients. Clinical studies did not include sufficient numbers of patients aged 65 years and over to determine differences in efficacy between elderly and younger patients. Other reported clinical or medical surveillance experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy. **ADVERSE REACTIONS** The following adverse reactions were reported in patients treated with PULMICORT FLEXHALER 180 or 90 mcg in two double-blind, placebo-controlled clinical trials in which 226 patients age 6-80 years, previously receiving bronchodilators, inhaled corticosteroids, or both, were treated with PULMICORT FLEXHALER, administered as 360 mcg twice daily for 12 weeks. The following table shows the incidence of adverse events (whether considered drug-related or non-drug-related by the investigators) that occurred at a rate of $\geq 1\%$ in the PULMICORT FLEXHALER group and were more common than in the placebo group.

Adverse Events with $\geq 1\%$ Incidence and with Incidence Greater than Placebo, Reported by Patients on PULMICORT FLEXHALER 180 or 90 mcg

Adverse Event	PULMICORT FLEXHALER 360 mcg twice daily N=226	Placebo N=230
Nasopharyngitis	9.3	8.3
Nasal congestion	2.7	1.4
Pharyngitis	2.7	0.7
Rhinitis allergic	2.2	1.3
Viral upper respiratory tract infection	2.2	1.3
Nausea	1.8	0.9
Viral gastroenteritis	1.8	0.4
Otitis media	1.3	0.9
Oral candidiasis	1.3	0.4
Average exposure duration (days)	78.2	68.2

Long-Term Safety Non-placebo controlled long-term studies in children (at doses up to 360 mcg daily), and adolescent and adult subjects (at doses up to 720 mcg daily), treated for up to one year with PULMICORT FLEXHALER, revealed a similar pattern and incidence of adverse events. **Adverse Event Reports from Other Sources** The following other adverse events occurred in placebo-controlled clinical trials with similar or lower budesonide doses with PULMICORT TURBUHALER with an incidence of $\geq 1\%$ in the budesonide group and were more common than in the placebo group: $\geq 3\%$ respiratory infection, sinusitis, headache, pain, back pain, fever, $\geq 1-3\%$ neck pain, syncope, abdominal pain, dry mouth, vomiting, weight gain, fracture, myalgia, hypertension, migraine, ecchymosis, insomnia, infection, taste perversion, voice alteration. Higher doses of PULMICORT TURBUHALER 800 mcg twice daily resulted in an increased incidence of voice alteration, flu syndrome, dyspepsia, gastroenteritis, nausea, and back pain, compared with doses of 400 mcg twice daily. In a 20-week trial in adult asthmatics who previously required oral corticosteroids, the effects of inhaled budesonide with PULMICORT TURBUHALER 400 mcg twice daily (N=53) and 800 mcg twice daily (N=53) were compared with placebo (N=53) on the frequency of reported adverse events. In considering these data, the increased average duration of exposure for inhaled budesonide patients (78 days for inhaled budesonide vs. 41 days for placebo) should be taken into account. Adverse events, whether considered drug-related or non-drug-related by the investigators, reported in more than five patients in the budesonide group and which occurred more frequently with budesonide than placebo are given (% inhaled budesonide and % placebo): asthenia (9% and 2%), headache (12% and 2%), pain (10% and 2%), dyspepsia (8% and 0%), nausea (6% and 0%), oral candidiasis (10% and 0%), arthralgia (6% and 0%), cough increased (5% and 2%), respiratory infection (32% and 13%), rhinitis (6% and 2%), sinusitis (16% and 11%). Rare adverse events reported in the published literature or from worldwide marketing experience with any formulation of inhaled budesonide include: immediate and delayed hypersensitivity reactions including rash, contact dermatitis, urticaria, angioedema and bronchospasm; symptoms of hypercorticism and hypercorticism; glaucoma, cataracts, psychiatric symptoms including depression, aggressive reactions, irritability, anxiety and psychosis. **OVERDOSEAGE** The potential for acute toxic effects following overdose of PULMICORT FLEXHALER is low. If used at excessive doses for prolonged periods, systemic corticosteroid effects such as hypercorticism may occur (see PRECAUTIONS). Another budesonide-containing dry powder inhaler at 3200 mcg daily administered for 6 weeks caused a significant reduction (27%) in the plasma cortisol response to a 6-hour infusion of ACTH compared with placebo (14%). The corresponding effect of 10 mg prednisone daily was 35% reduction in the plasma cortisol response to ACTH. The minimal inhalation lethal dose in mice was 100 mg/kg (approximately 280 times the maximum recommended daily inhalation dose in adults and approximately 336 times the maximum recommended daily inhalation dose in children on a mcg/m² basis). There were no deaths following the administration of an inhalation dose of 58 mg/kg in rats (approximately 380 times the maximum recommended daily inhalation dose in adults and approximately 450 times the maximum recommended daily inhalation dose in children on a mcg/m² basis). The minimal oral lethal dose was 200 mg/kg in mice (approximately 560 times the maximum recommended daily inhalation dose in adults and approximately 670 times the maximum recommended daily inhalation dose in children on a mcg/m² basis). Post-mortem experience showed that acute overdose of inhaled budesonide commonly remained asymptomatic. The use of excessive doses (up to 6400 mcg daily) for prolonged periods showed systemic corticosteroid effects such as hypercorticism. **Patients Maintained on Chronic Oral Corticosteroids** Clinical studies with PULMICORT FLEXHALER did not evaluate patients on oral corticosteroids. However, clinical studies with therapeutic doses of PULMICORT TURBUHALER did show efficacy in the management of asthmatics dependent or maintained on systemic corticosteroids. If a patient is already on a systemic corticosteroid for asthma control, PULMICORT FLEXHALER should be used concurrently with the patient's usual maintenance dose of systemic corticosteroid. The patient's asthma should be reasonably stable before withdrawal of oral corticosteroids is initiated. After approximately one week, gradual withdrawal of the systemic corticosteroid may be started by reducing the daily or alternate daily dose. The next reduction is made after an interval of one or two weeks, depending on the response of the patient. Generally, these decrements should not exceed 2.5 mg of prednisone or its equivalent. A slow rate of withdrawal is strongly recommended. During reduction of oral corticosteroids, patients should be carefully monitored for asthma instability, including objective measures of airway function, and for adrenal insufficiency (see WARNINGS). During withdrawal, some patients may experience symptoms of systemic corticosteroid withdrawal, eg, joint and/or muscular pain, lassitude, and depression, despite maintenance or even improvement in pulmonary function. Such patients should be encouraged to continue with PULMICORT FLEXHALER but should be monitored for objective signs of adrenal insufficiency. If evidence of adrenal insufficiency occurs, the systemic corticosteroid doses should be increased temporarily and thereafter withdrawal should continue more slowly. During periods of stress or a severe asthma attack, transfer patients may require supplementary treatment with systemic corticosteroids. **Directions for Use:** Illustrated Patient's Instructions for Use accompany each package of PULMICORT FLEXHALER. Patients should be instructed to prime PULMICORT FLEXHALER prior to its initial use, and instructed to inhale deeply and forcefully each time the unit is used. Rinsing the mouth after inhalation is also recommended (see further instructions in PRECAUTIONS, Information for Patients).

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Improved Ped Paxil Settlement

Public Citizen said it has won greater compensation for parents of children who took the antidepressant Paxil but can't provide documentation of their purchase or related costs. In an earlier complaint (*Hoormann et al. v. SmithKline Beecham Corp.*), the defendants alleged the company misled parents by not disclosing that the drug was dangerous and ineffective for children younger than age 18 years. Paxil maker GlaxoSmithKline Inc. was required to pay \$63.8 million into a fund to pay class members' out-of-pocket expenses and attorneys' fees, but members who could not provide proof of expenses were limited to a \$15 payout and a pro rata share of \$300,000, depending on the number of claimants. In a revised settlement approved by the Third Judicial Circuit of Madison County, Ill., claimants without documentation will now get up to \$100, and the \$300,000 pro rata cap is eliminated, according to the organization Public Citizen. Information on the settlement is at www.paxilpediatricsettlement.com.

Hawaii to Offer Kids Free Flu Shots

This fall, Hawaii will become the first state to offer free influenza vaccinations to school children aged 5-13 years. The shots will be available October 2007-January 2008 at school during the school day. Funding for the estimated \$2.5 million program is being provided primarily by the Centers for Disease Control and Prevention and the State of Hawaii, with additional support from the state's largest insurer, the Hawaii Medical Service Association. Nationally, school children have very high rates of influenza illness, exceeding 10% in most years, according to the Hawaii State Department of Health.

AAOS Warns About Wheeled Shoes

The American Academy of Orthopaedic Surgeons (AAOS) has warned that children who wear roller shoes or street gliders—shoes with wheels in the heel—should wear protective gear such as wrist guards and helmets to avoid injuries. According to AAOS President James Beaty, a pediatric orthopaedic surgeon, physicians are seeing children come into their practices with injuries—mostly fractures with-tributable to these shoes. The Consumer Product Safety Commission said the agency received reports of one death and at least 64 injuries related to wheeled sneakers between September 2005 and December 2006.

—Jane Anderson