

Asthma: A Growing Health Problem In Young Children

(NAPSA)—Approximately six million children in the United States have asthma, a chronic respiratory disease. More than one million of these children are under the age of 5. Far from being a trivial illness, asthma is on the rise and can be life threatening if not managed properly. It is the most common chronic disease of childhood and the estimated cost for treating children with asthma in the United States is \$3.2 billion annually.

Asthma attacks, which can result in scary trips to the hospital for many children, account for 17 percent of all pediatric emergency room visits. Young children are at particular risk, with the Centers for Disease Control reporting that children ages 4 and younger have the highest rate of emergency room visits and hospitalizations for asthma.

“When I talk to parents whose young children have asthma, they are already nervous about the condition,” says Gail Shapiro, M.D., a

pediatric asthma and allergy physician at the Northwest Asthma and Allergy Center in Seattle. “It’s important to have easy-to-use treatment options available.”

Currently, the most common controller medication for pediatric patients with asthma 12 to 23 months of age is an inhaled corticosteroid administered through a nebulizer machine.

The most prescribed asthma controller medicine for young people under age 14 is currently SINGULAIR (montelukast sodium). SINGULAIR is indicated for the prophylaxis and chronic treatment of asthma in adults and pediatric patients 12 months of age and older. SINGULAIR should not be used for the immediate relief of asthma attacks or to prevent or treat asthma made worse by exercise. Recently, SINGULAIR has become available in a new, easy-to-use “oral granules” formulation for children aged 12 months to 5 years with asthma.

The new formulation can be given alone or served cold or at room temperature mixed with applesauce, mashed carrots, rice or ice cream. All of the medication must be given to the child within 15 minutes of opening the packet and any leftovers must not be stored for future use. Oral granules should not be mixed in a liquid drink. SINGULAIR should be taken once daily in the evening as prescribed whether or not your child has asthma symptoms. If your child’s symptoms get worse or you need to increase the use of your child’s rescue inhaler, call the doctor at once.

Important Information: Patients who have asthma made worse by exercise should continue to use their existing medications prior to exercise unless instructed otherwise by their doctor and should be advised to have appropriate rescue medication available. While the dose of inhaled corticosteroid may be reduced gradually under medical supervision, SINGULAIR should not be abruptly substituted for inhaled or oral corticosteroids.

SINGULAIR is not an inhaler and not a steroid. SINGULAIR works by blocking substances in the body called leukotrienes, which have been associated with the symptoms of asthma. The once-a-day treatment option can help control asthma for 24 hours. It is available for children and adults.

Efficacy of SINGULAIR in patients 12 months to 5 years of age with asthma is based on extrapolation of the demonstrated efficacy in patients 6 years of age and older with asthma. In clinical studies for asthma, adverse experiences were generally mild and varied by age. The most commonly reported adverse experiences in adults and adolescents 15 years and older, occurring more often than with placebo regardless of causality assessment, were headache, influenza, abdominal pain, cough, and dyspepsia. The safety profile in pediatric patients 6 to 14 years of age was similar to placebo and the adult safety profile. The safety profile in pediatric patients 2 to 5 years of age was similar to that in patients 6 to 14 years of age. The most frequently reported additional adverse events in pediatric patients, regardless of causality assessment, included pharyngitis, diarrhea, and fever. In pediatric patients 12 to 23 months of age receiving SINGULAIR, the following events occurred with a frequency $\geq 2\%$ and more frequently than in pediatric patients who received placebo, regardless of causality assessment: upper respiratory infection, wheezing; otitis media; pharyngitis, tonsillitis, cough; and rhinitis. The frequency of less common adverse events was comparable between SINGULAIR and placebo. Long-term trials evaluating the effect of chronic administration of SINGULAIR on linear growth in pediatric patients have not been conducted. SINGULAIR is available by prescription only. For more information on SINGULAIR visit www.singulair.com. Please see the adjacent patient product information and discuss it with your doctor.



Detecting Asthma

Did you know that one-third of children with asthma have symptoms before their first birthday? Half will have symptoms by age 2. If you think your child may have asthma, check with the doctor. Here are some signs to look for:

- Recurrent wheezing
- History of allergies
- Recurrent cough
- Breathing that is affected by temperature and humidity changes, particularly cold weather
- Many viral respiratory infections, such as bronchitis and pneumonia
- Difficulty breathing after laughing or crying

In addition, approximately 2 out of 5 children who have asthmatic parents will develop asthma. Because there is a genetic predisposition to asthma, it is important to provide the doctor with your child's family medical history.

