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# Integrating high dose inhaled corticosteroids into oral corticosteroids stewardship

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If high doses of ICS are equivalent to low dose OCS, they should be considered as such

<http://bit.ly/2CYssfB>

**Cite this article as:** Bourdin A, Suehs C, Charriot J. Integrating high dose inhaled corticosteroids into oral corticosteroids stewardship. *Eur Respir J* 2020; 55: 1902193 [<https://doi.org/10.1183/13993003.02193-2019>].

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Uncertainties still surround high dose inhaled corticosteroids (ICS) use in asthma. In hindsight, certain aspects of the ICS development story can help elucidate why. In 1973, CAMERON *et al.* [1] signed a brilliant paper reporting the results of a double blind, randomised controlled trial demonstrating the oral corticosteroid (OCS)-sparing effect of ICS as the primary outcome. A few years later, the assessment of this benefit was mitigated when a complete weaning of OCS remained unachievable [2]. The benefit of ICS was therefore understood to be mostly based on an improved safety profile purportedly due to reduced systemic diffusion. Thus, the understanding of how ICS was of any benefit to asthma patients when compared to OCS was mostly based on a greater safety profile supposedly due to a reduced systemic diffusion. Similarly, topically administered corticosteroids were also developed in the same time period for diseases affecting the skin, the eyes, the nose or the joints. As for ICS, whether or not these formulations reduce corticosteroid-associated adverse events remains largely debated [3].