Nebulised bronchodilators, corticosteroids, and rhDNase in adult patients with cystic fibrosis

S P Conway, A Watson

**Bronchodilator therapy**

Bronchodilators are commonly prescribed for adult patients with cystic fibrosis and their judicious use is seen by most physicians as “good clinical practice”. There is, however, a dearth of clinically relevant research addressing their efficacy, optimal dosage, method of delivery, or responses to single and combined therapy with β agonists and anticholinergic agents. The importance of allergy and hyper-reactivity remains poorly understood. Published studies are bedevilled by small patient numbers, short term results, often heterogeneous patient groups, different outcome criteria, and a concentration on the use of metered dose inhalers.

**RATIONALE FOR BRONchodilATOR USE IN ADULT PATIENTS WITH CYSTIC FIBROSIS**

The lungs of patients with cystic fibrosis are progressively compromised by airway obstruction, compromised airflow, and fixed structural damage to the bronchial tree from ongoing airway inflammation may all contribute to symptoms. Lung function is compromised by air trapping, loss of lung recoil, and reduced expiratory flow, with resulting wheeze and exercise limitation, but airway obstruction is not irreversible in all patients. Bronchial constriction responsive to bronchodilator therapy makes a variable contribution to the overall airway obstruction.

Bronchodilators are beneficial during hospital admissions for intravenous antibiotic treatment of acute respiratory exacerbations when airway obstruction is often increased. Nordvik et al showed responsiveness to nebulised isethionate increasing during hospitalisation, with the response significantly correlating with improvements in baseline forced expiratory volume in one second (FEV1), forced vital capacity (FVC), and mid forced expiratory flow (PEF_{50-75}) measurements. This probably reflects bronchodilator induced mobilisation of secretions with resultant increases in lung function.

The ability of bronchodilator drugs to increase mucociliary clearance may be as important as their primary action and they are particularly useful before chest physiotherapy or bronchial drainage.

**BRONCHIAL HYPERREACTIVITY IN PATIENTS WITH CYSTIC FIBROSIS**

Bronchial hyperreactivity, shown by short term improvement in spirometric values after bronchodilators and by positive bronchoprovocation tests (see below), has been reported in 25–66% of study populations. Although hyperreactivity may be a distinct and separate condition in patients with cystic fibrosis, it is more likely to be a reflection of the underlying disease, the progressive inflammation and epithelial damage altering mucosal permeability and histamine penetration. Both the extent and prevalence of bronchial hyperreactivity and obstruction may increase with age. Thus, as airways become more structurally damaged they may also become more responsive to bronchodilator treatment. Probably because of the additional factor of airway instability, the bronchial hyperreactivity seen in cystic fibrosis differs from that seen in uncomplicated asthma. The less responsive cystic fibrosis airway may require optimally delivered, high dose, long term bronchodilators to maximise the therapeutic response.

**EVIDENCE FOR THE EFFICACY OF BRONchodilATOR THERAPY IN CYSTIC FIBROSIS**

There is a paucity of acute response data to bronchodilators and no studies of long term nebulised bronchodilator therapy in cystic fibrosis. It is therefore necessary also to refer to data from work on delivery by metered dose inhaler. Inhalation of high dose nebulised bronchodilator for 10 minutes might reasonably be expected to have the greater efficacy, given the viscous mucus barrier between drug and receptor. Mixed study populations of adults and children have shown significant increases in expiratory flow in up to one third of patients after β agonist or anticholinergic bronchodilators delivered by metered dose inhaler and nebuliser. Adult patients are more likely to show a response.
Assessment of bronchodilator responsiveness in individual patients is complicated further by within patient variability, reflecting the fluctuations in the degree of inflammation, secretory load, mucosal oedema, or bronchospasm present at different points in time, and the effect of acute infective changes on the underlying chronic lung disease. Most studies have reported no relationship between the degree of bronchodilator response and atopy.12 16

Corticosteroid therapy
Inhaled corticosteroids, delivered by metered dose inhaler or nebuliser, are widely used in the management of adult patients with cystic fibrosis. There are few controlled studies documenting the efficacy of inhalers and no studies on the use of nebulised corticosteroids.

Combined β agonist and anticholinergic therapy
Nebulised bronchodilator therapy appears to be a useful adjunct in the management of acute respiratory exacerbations.14 Hordvik et al showed significant improvements in baseline spirometric tests in patients admitted to hospital treated with either nebulised albuterol or placebo before physiotherapy.15

The potential for an additive bronchodilator effect by combining ipratropium bromide and a β agonist has not been widely addressed. Weintrath et al studied the acute response to inhaled placebo, ipratropium bromide 40 µg, metaproterenol 1500 µg, and combined bronchodilator therapy delivered by metered dose inhaler in 10 randomly selected adult patients.16 Eight had a clinically significant improvement with at least one of the regimens, with a tendency for those who responded to one regimen to respond to the others. Only two of the 10 patients showed a marked benefit from combination therapy. Sanchez reported a better response of respiratory function tests (FEV1 increasing by 17%) and airway resistance to albuterol 5 mg and ipratropium bromide 250 µg delivered by nebuliser and face mask than to either drug when used alone in a mixed patient group of children and adults. Ipratropium bromide was needed to achieve a fall in FRC and residual volume (RV).17

Ipratropium bromide appears to be more effective in patients with negative broncho-provocation test results.18 We recommend that all patients should have respiratory function tests monitored before and after inhalation of both β agonists and anticholinergic bronchodilators, singly and in combination, to determine the optimal treatment regimen.

Potential for a differentially bronchodilator effect on lung function in adult cystic fibrosis
Zach18 has proposed, on theoretical grounds, that bronchodilation may reduce end expiratory flow rates and thus perhaps reduce coughing efficiency. The relevance of this to clinical practice is uncertain.19 Deterioration after inhaled bronchodilator treatment is rare20 21 26 27 28 and is not a problem in practice.

Conclusion
A significant percentage of adult patients with cystic fibrosis may benefit from bronchodilator therapy. There is no reliable method for predicting those patients who will respond and all patients should be given a trial of nebulised bronchodilators when clinically indicated.

Indications
Three indications for inhaled corticosteroids:
1. The treatment of bronchial hyperreactivity associated with a worse prognosis and more severe exacerbations.26
2. To decrease the destructive inflammatory responses. Persistent airway inflammation, rather than infection, produces the most significant lung damage in cystic fibrosis.22 Even patients with mild disease (mean FEV1 >80% predicted value) show a marked inflammatory response in the epithelial linings.23 A double blind randomised study of alternate day oral prednisone (2 mg/kg to a maximum of 60 mg) in 45 children with cystic fibrosis improved lung function and reduced the need for hospital admission.24 Larger follow up studies, however, showed an unacceptable incidence of adverse side effects.25 Inhaled corticosteroids may confer clinical benefit without producing these side effects, both during acute and chronic respiratory exacerbations26 and as maintenance therapy.27 28
3. To reduce the progressive decline of FEV1. Retrospective and prospective studies of inhalated corticosteroids in patients with chronic obstructive pulmonary disease suggest that they may reduce the rate of decline of respiratory function43 44 but there is no evidence in patients with cystic fibrosis.

Conclusions
Inhaled corticosteroids have significant theoretical therapeutic potential in cystic fibrosis where ongoing inflammation is at the heart of the disease process. It would be reasonable to consider treating those patients who have shown reversibility with bronchodilators, a history of asthma or allergy, or a previous response to oral prednisolone, although there is no reason to deny any patient a therapeutic trial. We do not know the optimal dose, nor if delivery by nebuliser is more effective than by metered dose inhaler. Studies in chronic obstructive pulmonary disease, however, suggest that high doses are needed for maximal effect. Well defined, controlled clinical trials are urgently needed. We favour twice daily, high dose (1 mg) nebulised budesonide as additional treatment for a respiratory exacerbation and for maintenance therapy. Patients already receiving nebulised antibiotics, bronchodilators, and/or rhDNase may not comply with this additional treatment.
rhDNase (Dornase alpha, Pulmozyme)

The epithelial lining fluid from the lung of patients with cystic fibrosis shows a large predominance of polymorphonuclear leucocytes compared with normal controls. The thick purulent sputum characteristic of cystic fibrosis is enriched with DNA derived from disintegration of these neutrophils as the inflammatory process outstrips the ability of deoxyribonuclease 1 (DNase 1), a naturally occurring human enzyme, to digest extracellular DNA. The latter group has since shown a significant efficacy of treatment by binding aminoglycoside antibiotics. The more powerful CR50 antibiotics have been shown to have markedly increased levels of DNA in their sputum. Compared with placebo, FEV1 increased by 7% and FVC by 5% with treatment. The study power was insufficient to show a significant reduction in infective exacerbations in the treatment group.

SUMMARY OF PHASE I, II, AND III TRIALS

In phase I studies, rhDNase was well tolerated at a maximum dose of 30 mg/day with significant improvement in lung function. FEV1 increased by 10–20% from baseline but returned to pretreatment levels within one week of the study. As the total sputum volume did not increase with treatment it was hypothesised that rhDNase enhanced the removal of mucus from areas where the normal cough and mucociliary mechanisms were ineffective. Phase II studies confirmed the safety profile of the drug and showed short term efficacy. Almost one third of patients showed a >20% increase in FEV1, with 2.5 mg rhDNase twice daily. Both studies reported a significant reduction in subjective perception of cystic fibrosis related symptoms. Adverse events were limited to mild upper airway irritation. A double blind placebo controlled phase III study in 968 patients over 24 weeks showed a sustained improvement in FEV1 of approximately 6% and a reduced relative risk of a respiratory exacerbation requiring intravenous antibiotics of 31% in patients treated with rhDNase 2.5 mg once or twice daily. Patients experienced less dyspnoea and an increased sense of well being. The major side effect was transient voice alteration. This trial was continued as an open label study of rhDNase, 2.5 mg daily, and the treatment continued to be well tolerated at two years. The risk of infection related respiratory infection remained lower than during placebo treatment and the improvement in respiratory function was maintained. Subgroup analysis of the phase III study showed that patients with mild lung disease (baseline FVC >85% predicted) also benefited from treatment with a decrease in the relative risk of pulmonary exacerbations and an increase in FVC of about 4%. Chronic inflammation is present even in the mildly affected lung. By mobilising secretions and decreasing the incidence of respiratory exacerbations, rhDNase may effect a delay in the progression of lung disease in these patients.

LATEST RESEARCH

Early studies of rhDNase use in acute respiratory exacerbations and severe disease (FVC <40%) were not sufficiently powerful to assess efficacy but showed good patient tolerance of the drug. An open label 12 week study in the latter group has since shown a significant increase in lung function, perhaps not surprising as all severely affected patients are likely to have markedly increased levels of DNA in their sputum. Compared with placebo, FEV1 increased by 7% and FVC by 5% with treatment. The study power was insufficient to show a significant reduction in infective exacerbations in the treatment group.

PRACTICAL ASPECTS OF rhDNASE ADMINISTRATION IN CYSTIC FIBROSIS

Patients should commence treatment with rhDNase under the guidance of a cystic fibrosis centre to ensure that they receive the proper training for drug administration, and the maintenance and cleaning of the equipment. Daily treatment is necessary to maintain the therapeutic benefit. Patients must use a recommended nebuliser system only and inspire at a normal rate and depth through a mouthpiece while sitting upright. Currently recommended delivery systems include the Hudson T Up-draft II, Marquest Acorn 11, or the Respirgard II with the DeVilbiss Pulmo-Aide compressor, the Pari LC nebuliser/Pari Proneb compressor, the Airlife Misty with Tee Adaptor, the Pari LL with the Inhalerboy or Master compressor, the Aiolos with an Aiolos compressor, or a Sidestream nebuliser with a CR50 compressor. The latter is used by most UK centres and can be obtained through Genentech-Roche. The more powerful CR60 compressor coupled with the Sidestream nebuliser may be more effective in severe lung disease but should not be used until evaluated by further clinical trials. Only jet nebulisers have been shown to deliver rhDNase effectively. Ultrasonic devices may cause thermal coagulation of rhDNase. Battery operated compressors have insufficient power.

The following points need to be emphasised when rhDNase is prescribed:

1. To prevent degradation of the protein, rhDNase must be protected from excessive heat and strong light. It should be stored in its foil pouch in a refrigerator at 2–8°C. Special
cool boxes can be obtained for use when travelling. rhDNase should not be used if it has been exposed to room temperature for 24 hours or longer, or if it becomes cloudy or discoloured.

(2) rhDNase must not be combined with any other medications in the nebuliser as changing the characteristics of the solution might alter the rhDNase protein.

(3) We recommend that rhDNase be inhaled after morning physiotherapy or in the late afternoon or early evening. This will maximise the effect of the before bed physiotherapy session. It is advisable to leave about two hours - and an absolute minimum of half an hour - between rhDNase inhalation and physiotherapy. Similarly, at least half an hour should be allowed between nebulised rhDNase and any nebulised antibiotic inhalation.

Because of the cost of rhDNase and the importance of continued evaluation of this new therapy, the response of all treated patients must be repeatedly assessed by monitoring spirometric values, the frequency of respiratory exacerbations, and subjective changes in dyspnoea, cough, sputum production, fatigue, appetite, sleep, exercise tolerance, and ease of sputum clearance. Patients with moderate impairment of respiratory function are likely to respond within two weeks of starting treatment. More severely affected patients may benefit most from a reduction in the frequency of respiratory exacerbations and should be assessed over a period of months.

RECOMMENDATIONS FOR rhDNASE USE IN ADULT CYSTIC FIBROSIS

Studies to date document objective and subjective benefits from rhDNase 2.5 mg daily in patients with a wide range of disease severity. The recommendations of the North American Consensus Committee for initiating treatment with rhDNase are noticeably unrestricted. The only criterion is the physician’s judgement that there is sufficient lower airway inflammation for rhDNase to be of benefit. Any patient should be considered eligible for consideration to receive DNase “if such therapy is deemed appropriate by the cystic fibrosis specialist treating the patient.” 98 We would endorse these recommendations, remembering that, in a disease characterised by an annual fall in lung function that is eventually fatal at a mean age of about 30 years, any stabilisation is an important gain and any treatment that offers the possibility of improvement must be fully explored. The increase of about 6% in FEV1 values documented in phase III studies will accrue substantial benefit to the patient over time, especially when compared with the usual decline in respiratory function. Our own practice has been to offer rhDNase therapy to the following patients:

(1) All severe patients because of the potential for preservation of lung function. These patients may need more than 2.5 mg rhDNase daily. Any increase should be in increments of 2.5 mg with sufficient time allowed between them to assess any improved response. 99 There is almost no protocol experience of doses greater than 20 mg/day.

(2) All patients showing rapid deterioration in FEV1 despite maximal use of routine therapy.

(3) All patients with more than usual difficulties in expectorating tenacious secretions.

(4) Patients with mild to moderate disease severity (those shown to respond in phase I–III trials).

(5) Patients experiencing difficulty with moving secretions in an acute respiratory deterioration. We do not yet recommend prophylactic rhDNase in those with normal FEV1, or FVC values and no significant sputum production.

Nebulised bronchodilators, corticosteroids, and rhDNase in adult patients with cystic fibrosis

SP Conway and A Watson

Thorax 1997 52: 64
doi: 10.1136/thx.52.2008.S64

These include:

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes