Evidence to suggest that aminophylline should not be used in mild to moderate COPD exacerbations

Theophylline is one of those medications that has intrigued and possibly confused clinicians and pharmacologists alike since the mid 19th century. Related agents caffeine and theobromine were used in the 1930s as bronchodilators, and theophylline developed an established place in the management of acute airflow obstruction associated with asthma and chronic obstructive pulmonary disease (COPD) during the mid 1900s.1 Pharmacologically, theophylline is characterised principally as a phosphodiesterase (PDE) inhibitor. Its main biological action is to block the inactivation of cyclic AMP and cyclic GMP giving rise to bronchodilatation, increased ciliary beat frequency, and reduced inflammatory cell numbers in the airways. However, it has been observed that other PDE inhibitors do not exert such effects, which suggests that other activities may be relevant. Theophylline also acts as an adenosine receptor antagonist, which may be relevant to its desirable effects and probably gives rise to a number of the side effects seen with use of this agent including arrhythmias, mental agitation, and diuresis. As well as bronchodilatation, theophylline has a number of other potentially useful actions including improved gas exchange, respiratory stimulation, increased diaphragmatic performance, and improved exercise tolerance.1

The pharmacokinetics of theophylline are important because of its narrow therapeutic index. In the acute setting most authorities recommend a loading dose in naive patients followed by an infusion to maintain a serum concentration within the therapeutic range of 55–110 μmol/l. Because of the many factors which can affect theophylline metabolism including a number of potential drug interactions, therapeutic drug monitoring is recommended to avoid serious or even fatal toxicity. In elderly patients cardiac monitoring is advised to check for the emergence of serious tachyarrhythmias. Seizures are another potentially fatal complication.1

Current evidence in support of the use of theophylline in acute severe asthma or COPD is weak at best. With regard to COPD, a recent meta-analysis published by Barr and colleagues identified four small clinical trials of oral or intravenous theophylline (aminophylline) suitable for inclusion, comprising a total of 169 subjects.2 Summary data showed no benefit in terms of lung function, symptom scores or length of hospital stay, but a significant problem with side effects such as nausea and vomiting together with a non-significant increase in palpitations compared with placebo. They concluded that there was no clinical benefit, and this research informed the statements in both the UK and Australasian management guidelines on the subject that “it should only be used when there is an inadequate response to nebulised bronchodilators” (grade D, NICE guideline)1 and “the routine use of aminophylline is not recommended for acute exacerbations” (grade D, Thoracic Society of Australia and New Zealand guideline).3

A notable feature of published papers, including the meta-analysis by Barr et al., is the small sample size of previous studies. In this issue of Thorax an adequately powered study is published which more or less clarifies the picture regarding the use of aminophylline in acute exacerbations of COPD. Duffy and co-workers studied the effects of adding intravenous aminophylline to usual care in subjects admitted to hospital with an acute exacerbation of COPD. Eighty well matched, non-acidotic subjects were randomised in a double blind fashion to receive intravenous aminophylline 0.5 mg mg/kg/hour or placebo and were then followed for 5 days. All subjects received nebulised bronchodilator and oral corticosteroids. The study showed no difference in spirometric values between the two groups, and there was no difference in symptom scores or length of hospital stay. The mean theophylline level achieved in the intervention group was 73.4 μmol/l (range 62.9–83.9). A significant proportion of the participants receiving active treatment experienced adverse effects including nausea in 46%. In six subjects the drug was stopped due to possible side effects including one subject who experienced a seizure during the second hour of treatment (the drug level was in the therapeutic range at the time of the seizure (53 μmol/l) and the seizure was later attributed on clinical grounds to alcohol withdrawal).

As might be expected, the investigators did not include subjects with very severe exacerbations. Those with a pH of 7.32 or less were excluded from entry to the study. The subjects on active treatment sustained a small but significant change in gas exchange parameters with a fall in arterial carbon dioxide tension and a small rise in pH over the initial 2 hours of treatment. This finding would be in keeping with the drug’s known positive influence on respiratory drive.

Thus, in considering the generalisability of the study, aminophylline might still be considered in the management of life threatening episodes of COPD by an experienced doctor in selected cases, together with other measures such as non-invasive ventilation. In such circumstances the benefits of respiratory stimulation and any effect on respiratory muscles may be more important than bronchodilatation per se. However, for most clinical situations involving mild to moderate COPD exacerbations, we now have a clear answer to the question whether aminophylline should be used—and it is “no”. Thorax 2005; 60:709. doi: 10.1136/thx.2005.043760

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REFERENCES

Aminophylline for COPD exacerbations? Not usually

G I Town

COPD exacerbations
When should a long acting β agonist be added to an inhaled corticosteroid?

A E Tattersfield

Evidence suggests that adding a long acting β agonist provides more clinical benefit than doubling the dose of an inhaled steroid even for relatively low doses of inhaled corticosteroid

Meta-analyses are a mixed blessing: they can be helpful and they can be misleading, and meta-analyses of studies in asthma are no exception. They are misleading when they fail to make clear that the conclusions only pertain to patients fulfilling the inclusion and exclusion criteria for the original studies. To suggest that they either confirm what everyone knows or provide conclusions, from somewhat dubious sources with spurious precision, may be unduly cynical. Nevertheless, it appears to be difficult to identify questions where a meta-analysis is able to provide important new insights into asthma management.

Professor Beasley’s group in New Zealand has used meta-analysis in the past to look at the dose-response relationship for inhaled budesonide and fluticasone. The two meta-analyses included all studies that had assessed at least two doses of the inhaled corticosteroid in addition to placebo. The conclusion of the analyses was that, in patients with mild to moderate asthma, 80% of the maximum benefit occurs with fluticasone 70–170 μg/day (depending on the end point studied), and 90% of the maximum benefit with a dose of 100–250 μg/day. Similarly, 80% and 90% of the maximum benefit from budesonide was seen with doses of 200–400 μg/day and 300–600 μg/day, respectively. Although the mean forced expiratory volume in 1 second (FEV1) in these studies was 66% and 69% predicted, respectively, suggesting the patients had moderately severe asthma, the patients had to be considered to be safe on placebo since the meta-analyses only included placebo controlled trials. The findings are therefore only generalisable to patients for whom it was considered safe to give no inhaled corticosteroid for several weeks, usually 8 weeks or more. That will include a fair proportion of patients in general practice but fewer in secondary care. The authors recognised this in the conclusion of their second paper, but the caveat is sometimes lost when the data are discussed.

The most recent meta-analysis from the New Zealand group by Masoli and colleagues published in this issue of Thorax is asking an important question and appears to have circumvented many of the problems outlined above. The authors examine whether, in adults with symptomatic asthma, it is better to add salmeterol to a moderately low dose of inhaled corticosteroid (fluticasone 200 μg/day or equivalent) or to increase the dose of inhaled corticosteroid. The analysis included randomised double blind trials and the main outcome measure was the number of subjects withdrawn due to asthma or who had one or more moderate or severe exacerbations. The authors found more withdrawals due to asthma and severe exacerbations in patients taking higher doses of inhaled corticosteroids than in those given salmeterol with the lower dose of inhaled corticosteroid, with odds ratios of 1.58 and 1.35 respectively. The changes in the secondary end points were in the same direction. The differences between groups are not particularly large, but are worthwhile when talking about important end points such as exacerbations.

The strengths of this meta-analysis are that it covers over 4000 patients from 12 studies and the main end point of deteriorating asthma or exacerbations is clinically important and not directly related to bronchodilator activity. The patients had moderately severe asthma with a mean FEV1 of 64% predicted and did not have to be deemed to be safe to use no inhaled corticosteroids. The question is also important since, although there is reasonable agreement that, in general, adding a long acting β agonist provides more clinical benefit than doubling the dose of an inhaled steroid, the dose of inhaled steroid at which the addition of a long acting β agonist is beneficial has not been clearly determined. This study suggests that patients taking 200 μg fluticasone or 400 μg beclomethasone or budesonide are likely to fare better if they add salmeterol rather than increasing the dose of inhaled steroid. Quadrupling rather than doubling the dose of inhaled steroid might provide more benefit, as shown in the FACET study with budesonide and formoterol, but this would involve relatively high doses of inhaled steroid.

Meta-analyses nearly always focus on efficacy rather than the balance of efficacy and adverse effects which is what, of course, a clinician has to take into account before prescribing. Both inhaled corticosteroids and long acting β agonists have a good safety record. There may be individual patients, however, where a physician might be influenced by potential adverse effects—patients with osteoporosis or a tendency to develop cardiac dysrhythmias, for example.

Masoli and colleagues limited their analysis to salmeterol because few studies with formoterol fulfilled the inclusion criteria for the meta-analysis. They argue that the effect of formoterol is likely to be similar to that of salmeterol, and this is supported by the findings of the FACET study. The conclusion that patients who are inadequately controlled on a relatively low dose of inhaled corticosteroid are more likely to benefit from a long acting β agonist rather than an increased dose of inhaled corticosteroid should enable firmer advice on this point to be incorporated into guidelines.

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REFERENCES


Glucose, bronchial secretions and MRSA

Association of MRSA infection with abnormal glucose levels in respiratory tract secretions

Strains of Staphylococcus aureus resistant to first line antibiotic therapy (the penicillinase resistant penicillins cloxacillin, flucloxacillin and methicillin), termed methicillin resistant S aureus (MRSA), first appeared in 1961 and are now widespread worldwide. In the UK MRSA is particularly prevalent, especially on intensive care wards, causing a variety of important nosocomial infections. Infection with MRSA usually requires parenteral therapy with a glycopeptide antibiotic and frequently substantially prolongs the patient’s hospital admission. Isolation of carriers places considerable stress on available bed resources and local outbreaks can even result in temporary ward closures. As a consequence, the human and financial burden of MRSA is significant, and this is reflected by the adoption of improved control of hospital acquired infections by a major political party as a major election “pledge”.

The paper by Philips et al in this issue of Thorax reports a possible association between a positive culture for MRSA from bronchial aspirates from patients in an intensive care ward and abnormally high levels of glucose in the bronchial aspirates (ranging from 2.7 to 4.4 mmol/l). MRSA infection was just over twice as likely in patients with abnormal glucose levels in bronchial aspirates, but the overall incidence of 45% for isolation of MRSA from the respiratory tract is surprisingly high and may limit the applicability of these results to other hospitals. However, if the association of MRSA with abnormal glucose levels in respiratory secretions is reproducible, it does offer a potential way of identifying patients at risk of MRSA infection. Hyperglycaemia is associated with both an increased severity of pneumonia and with death from sepsis for twice as likely in patients with abnormal glucose levels in bronchial aspirates, providing support for a relationship between infection and high levels of glucose in respiratory secretions. However, many questions remain about the role of glucose in bronchial secretions and a possible increased risk of infection.
Aspergillus fumigatus, can use glucose as a carbon source. Therefore, if abnormal glucose levels in respiratory secretions do lead to an increase in infection, the pathogens affected will probably not be limited to MRSA. This may have implications in controlling infection in other patient groups—for example, patients with cystic fibrosis who frequently have co-existent diabetes and chronic bronchial suppuration, or patients on long term corticosteroid treatment for chronic lung conditions such as pulmonary fibrosis and asthma.

The novel observation by Philips et al. that MRSA infection is associated with abnormal glucose levels in respiratory tract secretions may eventually lead to improved control of MRSA and potentially other respiratory tract infections in high risk patients. However, further research is needed to evaluate the potential mechanisms underlying this observation to confirm whether abnormal glucose levels in respiratory secretions cause the increased risk of infection, and whether intervention to lower blood glucose levels will reduce the incidence of respiratory infection.

**Thorax**

5.040 in 2004.

has risen from 4.188 in 2003 to

Thorax readers know that the impact factor for 2003. We are very pleased to let all our

reflected the number of citations in 2004

over the last few years and this reflects

Impact factors for 2004

another rise for **Thorax**

J A Wedzicha, S L Johnston, D M Mitchell

The impact factor for **Thorax** continues to rise

to continue to send us your best papers. The increase in the impact factor reflects the success of the journal, and the future for **Thorax** is very good indeed.

**Thorax** 2005;60:712.
doi: 10.1136/thx.2005.050922

**Journal impact factors for 2004:**

**Table 1  Journal impact factors for 2004: respiratory journals**

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**References**


**Impact factors for 2004**

**Journal impact factors for 2004:** another rise for **Thorax**

J A Wedzicha, S L Johnston, D M Mitchell

The impact factor for **Thorax** continues to rise

The journal impact factors for the year 2004 have recently been announced. The impact factor reflects the number of citations in 2004 to the number of original papers and reviews published in **Thorax** in 2002 and 2003. We are very pleased to let all our readers know that the impact factor for **Thorax** has risen from 4.188 in 2003 to 5.040 in 2004. **Thorax** is the second highest ranked respiratory journal in terms of impact factor, behind the American Journal of Respiratory and Critical Care Medicine. The impact factors for the main respiratory journals are listed in table 1.

The impact factor for **Thorax** has risen over the last few years and this reflects the high quality original papers and reviews we have received for publication.1 2 In 2002 and 2003 we also published useful management guidelines for common conditions including the new British Thoracic Society (BTS)/Scottish Intercollegiate Guidelines Network (SIGN) guidelines for the management of asthma in February 2003,4 5 and BTS guidelines for the management of community acquired pneumonia in children,6 the use of non-invasive ventilation in acute respiratory failure,7 guidelines on air travel,8 the management of pulmonary embolism,8 9 the management of pleural disease,10 and on respiratory aspects of fitness for diving.11 Over the past few years we have seen a marked rise in submissions to the journal, especially of high quality original papers,12 and we very much urge you
Glucose, bronchial secretions and MRSA

J S Brown

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