Dose equivalence and bronchoprotective effects of salmeterol and salbutamol in asthma

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Abstract

Background — Salbutamol is the most widely prescribed short acting β₂ agonist and salmeterol is the first long acting inhaled β₂ agonist. The dose equivalence of salmeterol and salbutamol is disputed. Estimates of weight-for-weight dose ratio have ranged from 1:2 to 1:16. A study was undertaken to clarify the true dose ratio.

Methods — The bronchoprotection afforded against repeated methacholine challenge by inhaled salmeterol 25 μg and 100 μg and salbutamol 100 μg and 400 μg was compared in a randomised, double blind, placebo controlled, crossover trial. Subjects were 16 stable asthmatics with a baseline forced expiratory volume in one second (FEV₁) of ≥ 65% predicted, screening concentrations of 20% (PC₂₀FEV₁) of ≤ 8 mg/ml, and a shift in PC₂₀FEV₁ of more than two doubling concentration steps following inhalation of salbutamol 400 μg. On five separate occasions subjects underwent methacholine challenge before and 30 and 120 minutes after drug administration. PD₂₀FEV₁ was calculated for each challenge. FEV₁ at 90 minutes after drug administration was also recorded.

Results — Bronchoprotection afforded by salmeterol was increased at 120 minutes compared with 30 minutes and protection by salbutamol was decreased. Protection by both doses of salmeterol was similar to salbutamol 100 μg at 30 minutes but significantly greater at 120 minutes. FEV₁ at 90 minutes was significantly greater after salmeterol 100 μg than after placebo, but there were no other significant differences between treatments. Maximal observed protection was equivalent for salmeterol 100 μg and salbutamol 400 μg.

Conclusions — The data are compatible with a weight-for-weight dose ratio for salmeterol:salbutamol of ≤ 1:4.

Keywords: salmeterol, salbutamol, dose equivalence.

Inhaled β₂ adrenoceptor agonists are the most effective bronchodilators and are widely utilised for the relief and prophylaxis of bronchoconstriction in asthma. Until recently all available β₂ agonists had short durations of action. Salmeterol xinafoate is a recently introduced long acting inhaled selective β₂ adrenoceptor agonist which produces dose-dependent bronchodilatation, reduction in diurnal variation in peak expiratory flow, improvement in daytime and nocturnal symptoms, reduction in requirement for a short acting bronchodilator and increased quality of life in asthmatic patients. Bronchodilatation and protection against non-specific bronchial challenge with histamine or methacholine are maintained for at least 12 hours after a single dose of salmeterol compared with 4–6 hours after salbutamol.

Salmeterol and salbutamol have similar β₂ receptor selectivity but dose equivalence is disputed, estimates of the weight-for-weight dose ratio ranging from 1:2 to 1:16 in single dose studies. In the light of continuing debate regarding a possible association between the use of β₂ agonists and increasing asthma morbidity and mortality worldwide and concern about relative potencies of different agents, it is important that the relative potencies of these two drugs be defined.

Increased responsiveness to non-specific bronchoconstrictor agents is a characteristic feature of clinical asthma and inhaled histamine or methacholine bronchoprovocation tests are commonly used in diagnosis in patients who present with vague or atypical symptoms. The aim of this placebo controlled study was to compare the potency of salmeterol and salbutamol in asthmatic subjects by measurement of the protection afforded by salmeterol 25 μg and 100 μg and salbutamol 100 μg and 400 μg against repeated methacholine challenge. The design is a model for multidose comparison of inhaled bronchodilator drugs.

Methods

Subjects

Sixteen stable mild asthmatic subjects (seven men) of mean age 29 (range 22–42) years were studied (table 1). Three were smokers and one was an ex-smoker. Subjects were either members of hospital or medical school staff or patients recruited from outpatient clinics. All had a diagnosis of asthma as defined according to American Thoracic Society criteria. Mean time (range) since diagnosis was 17 (1–38) years and mean (SD) baseline forced expiratory volume in one second (FEV₁) was 101.2 (14.5)% predicted. Nine subjects used inhaled salbutamol as required, one inhaled terbutaline as required, and three inhaled salbutamol as required plus an inhaled glucocorticosteroid regularly. Three subjects were not currently taking any asthma medication. No subject was using salmeterol prior to the study. No subject had had a recent respiratory tract infection nor...
an exacerbation of asthma in the previous four
weeks. None had been admitted to hospital for
an exacerbation of asthma in the previous 12
months. The study was approved by the Royal
Postgraduate Medical School and Ham-
mersmith Hospital Research ethics committee
and written informed consent was obtained
from each subject prior to entry into the study.

STUDY DESIGN
The study was of a randomised, crossover,
double blind, double dummy design. Subjects
attended the laboratory for a screening visit
and five study visits at the same time of day,
with a washout period of at least three days
during which subjects were asked to avoid tea
and coffee for the same period because of the possible bronchodilator
effects of caffeine. At screening a medical
history was taken and methacholine challenge
was performed. Subjects participated in the
study if they had a provocative concentration
of methacholine causing a 20% fall in FEV₁
(PC_{20}FEV₁) of ≤ 8 mg/ml and a shift in
PC_{20}FEV₁ of more than two doubling
concentrations 30 minutes after inhalation of
salbutamol 400 μg, while remaining ≤ 64 mg/
ml. Baseline FEV₁ at each study visit was re-
quired to be ≥ 65% of the predicted value and
to not deviate by more than 15% from the
screening value. Baseline PC_{20}FEV₁ at
each visit was required to be within two
collection steps lower or one higher than the
collection value, and ≤ 8 mg/ml. If these criteria
were not met an appointment was made for
reattendance on another day.

On each study day baseline bronchial chal-
lenge with methacholine was performed. One
hour after commencing the challenge subjects
inhaled the study drug (salmeterol 25 μg or
100 μg, salbutamol 100 μg or 400 μg, or
placebo). This was administered in a ran-
domised, double blind, double dummy fashion.
Further methacholine challenges were per-
formed 30 and 120 minutes following drug
administration. In addition, FEV₁, was mea-
sured 90 minutes after dosing. At each visit
subjects inhaled salbutamol 400 μg im-
mediately after the final challenge to reverse
bronchoconstriction, and were allowed to leave
when their FEV₁ had returned to at least 80%
of its baseline value.

SPIROMETRY, DRUG DELIVERY AND
METHACHOLINE CHALLENGE
Spirometric measurements were made using
a dry wedge bellows spirometer (Vitalograph,
Vitalograph Ltd, Buckingham, UK) and per-
formed according to American Thoracic So-
ciety guidelines. The highest of a minimum
of three technically acceptable measurements
from a maximum of eight attempts was re-
corded. The two largest values from each set
of measurements were required to be re-
producible to within 5%.

Study medication (supplied by Glaxo Group
Research, Greenford, Middlesex, UK) was de-
ivered from blinded metered dose inhalers via
a large volume spacer (Volumatic, Allen &
Hanburys Ltd, Uxbridge, Middlesex, UK).
Subjects wore nose clips and were instructed
to breathe in and out through the valve in the
spacer five times to maximise drug delivery.

Methacholine responsiveness was assessed by
a standardised provocation technique similar
to that previously described. Methacholine
(Sigma, Poole, UK) aerosol was delivered via
Mefar dosimeter (Brescia, Italy) driven by com-
pressed air at a pressure of 1.5 kg/m² with a
one second actuation time and five seconds
breath-hold. Output of the dosimeter was 14 μl
per puff. At each challenge subjects inhaled
five puffs of diluent (isotonic saline) followed
by five puffs of doubling concentrations of
methacholine solution (minimum 0.0625 mg/
ml, maximum 128 mg/ml) until a 20% reduc-
tion in FEV₁ occurred or the highest con-
centration was administered. Measurements of
FEV₁ were made 90 seconds after aerosol
inhalation and subsequent doses of metha-
choline were given at three minute intervals.
In order to abbreviate the challenge procedure,
and since the algorithm used to calculate the
provocative dose causing a 20% fall in FEV₁
(PD₃₀FEV₁) utilises only the concentrations
of the two highest doses given,” study chal-
lenge were started at methacholine concentra-
tions three dose steps lower than that achieved at

<table>
<thead>
<tr>
<th>Table 1 Characteristics of subjects</th>
<th>Subject</th>
<th>Sex</th>
<th>Age (years)</th>
<th>Height (cm)</th>
<th>Baseline FEV₁ (% predicted)</th>
<th>Screening PD_{20} (μmol)</th>
<th>Asthma history (years)</th>
<th>Smoking status</th>
<th>Asthma medication</th>
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<td>1 F 34 166 90.9 0.68 33 N SALB, BDP</td>
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N = non-smoker; S = smoker; X = ex-smoker; SALB = salbutamol; TERB = terbutaline; BDP = beclometasone 500 μg bd; BUD = budesonide 200 μg bd.
Table 2 Mean (SD) FEV₁ in litres at baseline and 30, 90 and 120 minutes after drug administration.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Baseline</th>
<th>30 min</th>
<th>90 min</th>
<th>120 min</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>3.73(0.88)</td>
<td>3.47(0.89)</td>
<td>3.14(0.80)</td>
<td>3.40(0.82)</td>
</tr>
<tr>
<td>Salbutamol 100 µg</td>
<td>3.65(0.90)</td>
<td>3.81(0.98)</td>
<td>3.34(0.74)</td>
<td>3.60(0.82)</td>
</tr>
<tr>
<td>Salbutamol 400 µg</td>
<td>3.71(0.83)</td>
<td>3.94(0.93)</td>
<td>3.33(0.74)</td>
<td>3.63(0.81)</td>
</tr>
<tr>
<td>Salmeterol 25 µg</td>
<td>3.74(0.88)</td>
<td>3.71(0.94)</td>
<td>3.30(0.76)</td>
<td>3.66(0.79)</td>
</tr>
<tr>
<td>Salmeterol 100 µg</td>
<td>3.68(0.84)</td>
<td>3.83(0.98)</td>
<td>3.46(0.75)</td>
<td>3.76(0.87)</td>
</tr>
</tbody>
</table>

The data analysis means were adjusted for baseline patient and treatment. PD₂₀FEV₁ values for each challenge were obtained by linear interpolation from the cumulative log dose-response curve for that challenge. For PC₂₀FEV₁ values greater than 128 mg/ml a value of 130 mg/ml was assigned. All the data were then logged and analysed parametrically. The pre-dosing PD₂₀FEV₁ and the nature of the crossover design were taken into account in the analysis. Carry over, period and sequence effects were also investigated. The slopes of the FEV₁ changes measured during each challenge were analysed parametrically.

Results
Methacholine challenges were generally well tolerated, although subject no. 6 became uncomfortable and required 2.5 mg nebulised salbutamol for reversal of bronchoconstriction after the 120 minute challenge following salmeterol 25 µg. Adverse events considered to be related to study medication were tremor and headache in two different subjects, both after salbutamol 400 µg. These side effects are consistent with the known pharmacology of β₂ adrenoceptor agonists. Four subjects were required to attend extra study visits because of changes in baseline methacholine responsiveness—two subjects on one occasion, one on two occasions, and one on four occasions.

FEV₁
The effects of the different treatments on FEV₁ are shown in table 2. Tests for carry over and two-factor interactions with treatment were non-significant.

At 30 minutes after medication, prior to second bronchial challenge, mean FEV₁ was reduced after placebo (due to persistent bronchoconstriction following baseline methacholine challenge and possible diurnal variation) but increased after salmeterol 100 µg, salbutamol 100 µg, and salbutamol 400 µg. The absolute change in FEV₁ from baseline was significant in favour of all active treatments when compared with placebo (p ≤ 0.001). The increase in FEV₁ after salbutamol 400 µg was significantly greater than after salmeterol 25 µg (absolute difference = 0.24 l (95% CI 0.10 to 0.38), p = 0.001). There were no other significant differences between treatments.

The lowest FEV₁ achieved during the 30 minute methacholine challenge did not differ significantly on any of the study days. On all treatment days mean FEV₁ 90 minutes after dosing was reduced compared with the baseline value due to the preceding methacholine challenge, but further recovery occurred by 120 minutes. There was no significant difference between study treatments other than a significantly smaller reduction in FEV₁ after salmeterol 100 µg than after placebo (absolute difference = 0.31 l (95% CI 0.12 to 0.50), p = 0.002).

The mean FEV₁ 120 minutes after salmeterol 100 µg was increased compared with the baseline value whereas it was reduced for all other treatments. However, all active treatments showed a significantly smaller reduction in FEV₁ than placebo (p ≤ 0.011). The effect on FEV₁ was significantly greater after salmeterol 100 µg than after salmeterol 25 µg (absolute difference 0.16 l (95% CI 0.02 to 0.31), p = 0.028), salbutamol 100 µg (absolute difference 0.18 l (95% CI 0.04 to 0.32), p = 0.015), and salbutamol 400 µg (absolute difference 0.16 l (95% CI 0.02 to 0.31), p = 0.027). There were no other significant differences between treatments.

METHACHOLINE CHALLENGE PD₂₀FEV₁
The baseline geometric mean dose of methacholine causing a 20% reduction in PD₂₀FEV₁ (PD₂₀FEV₁) did not differ significantly between different treatment days. PD₂₀FEV₁ 30 and 120 minutes after dosing are shown in fig 1. All active treatments offered significantly better protection against methacholine-induced bronchoconstriction than placebo at 30 minutes (p<0.001) and at 120 minutes (p<0.001). Tests for carry over and two-factor interactions with treatment were found to be non-significant for both challenges. The results are shown in fig 2 and table 3 as doubling doses related to placebo response. Statistical analyses of treat-
Table 3  Mean (SE) PD_{20}FEV_{1} expressed as doubling doses of methacholine related to placebo response

<table>
<thead>
<tr>
<th></th>
<th>Salbutamol 25 µg</th>
<th>Salbutamol 100 µg</th>
<th>Salmeterol 25 µg</th>
<th>Salmeterol 100 µg</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 min</td>
<td>2.1(0.45)</td>
<td>3.7(0.44)</td>
<td>1.9(0.37)</td>
<td>2.8(0.32)</td>
</tr>
<tr>
<td>120 min</td>
<td>1.3(0.35)</td>
<td>2.3(0.32)</td>
<td>2.5(0.38)</td>
<td>3.2(0.36)</td>
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</tbody>
</table>

Table 4  Geometric mean PD_{20}FEV_{1} data at 30 and 120 minutes expressed as ratios between different treatments

<table>
<thead>
<tr>
<th></th>
<th>Salbutamol 25 µg</th>
<th>Salbutamol 100 µg</th>
<th>Salmeterol 25 µg</th>
<th>Salmeterol 100 µg</th>
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</thead>
<tbody>
<tr>
<td>30 min</td>
<td>5.7</td>
<td>9.3</td>
<td>2.5</td>
<td>5.2</td>
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<tr>
<td>120 min</td>
<td>3.8 to 8.6</td>
<td>6.1 to 14.1</td>
<td>1.7 to 3.9</td>
<td>3.4 to 7.9</td>
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</table>

Figure 2  Individual PD_{20}FEV_{1} data expressed as doubling doses of methacholine related to placebo response.
was equivalent for salmeterol 100 µg and salbutamol 400 µg but was significantly greater for salmeterol 25 µg than salbutamol 100 µg (p = 0.01). Salmeterol 25 µg was equivalent to salbutamol 100 µg at 30 minutes but significantly more effective at 120 minutes. At 30 minutes salmeterol 100 µg was less effective than salbutamol 400 µg while at 120 minutes it was significantly more effective. The magnitude of protection due to salmeterol increased over the course of 120 minutes, while protection afforded by salbutamol decreased. This is consistent with the known onset and duration of action of these drugs. It is compatible with previous studies showing a slower onset of action of salmeterol and a longer duration of action than salbutamol in human airways in vivo\(^7\) and in vitro.\(^20\)

Inevitably there are some limitations to a study of this nature. Only a relatively small number of subjects was studied but the study design ensured that the pre-drug methacholine challenge was reproducible by determination of baseline on each treatment day. Subjects were clinically stable throughout the duration of the study. Baseline FEV\(_1\), did not differ significantly between study days and was comparable to screening values, so the observed changes in FEV\(_1\) and PD\(_{20}\)FEV\(_1\), can confidently be attributed to drug and dose differences. The study methodology was adequate to distinguish a fourfold difference in dose for salbutamol. Methacholine challenge at 30 minutes and at 120 minutes could have been performed on different days to avoid possible cumulative bronchoconstriction, but such a design would be impractical and has not been adopted by others. It would be similarly onerous to increase the number of doses of each drug studied to construct full log dose-response curves.

No study has previously reported the bronchoprotective effects of salmeterol at exactly these doses and time points but our results are in line with those of other workers. Cheung and coworkers\(^8\) reported an acute protective effect of salmeterol 50 µg with a 2.3-fold doubling dose increase in PD\(_{20}\)FEV\(_1\) at one hour, whereas Derom et al\(^8\) found salmeterol 50 µg equivalent to salbutamol 200 µg with a 1.9-fold doubling dose increase in PC\(_{20}\)FEV\(_1\) at one hour. Gongora et al\(^7\) compared the protective effects of salmeterol and salbutamol, delivered by metered dose inhaler, against histamine challenge in a placebo controlled study. They reported an increase of 2.7 doubling doses of histamine one hour after salmeterol 50 µg compared with 1.8 after salbutamol 200 µg. These results are very comparable to our own. Our time points were chosen to obtain comparable bronchodilator effects of the two drugs, bearing in mind their different time courses of action.

It should be noted that bronchoprotective effects may not necessarily be identical to bronchodilator effects. However, it would be difficult to compare bronchodilator effects of the higher doses of the two β\(_2\)-agonists used due to the shape of the dose-response curve and the tendency of FEV\(_1\) to plateau below maximal therapeutic dosage so that increasing doses cannot be discriminated.\(^22\)

In the present study there was a trend for salmeterol 100 µg to exhibit a greater bronchodilator effect than salmeterol 25 µg after baseline methacholine challenge, as shown by FEV\(_1\) at 90 and 120 minutes, though this was not statistically significant. There was a trend to greater protection after salbutamol 400 µg than after salmeterol 100 µg, although this did not achieve statistical significance. We cannot exclude the possibility of a plateau bronchoprotective effect at the higher dose of salbutamol, suggesting that the relative potency ratio for salmeterol to salbutamol might be slightly less than 1:4. Comparison of the effects of β\(_2\)-adrenoceptor agonists on methacholine responsiveness therefore offers a sensitive, convenient and reproducible method for comparing potency of drugs of this class, and has been recommended as a method for determining equivalence of inhaled medications.\(^22\)\(^23\)

In vitro studies suggest a fourfold greater affinity of salmeterol for β\(_2\) receptors and that salmeterol is 2–15 times more potent than salbutamol.\(^20\)\(^29\) Previous single dose studies in vivo in humans have suggested a dose equivalence of salmeterol compared with salbutamol of 2–16, but these studies have largely relied on change in FEV\(_1\). As discussed above, this is an insensitive method of estimating relative potency. A more comprehensive study compared cumulative doses of salbutamol with three single doses of salmeterol.\(^11\) Heart rate, plasma potassium, QTc interval, and tremor were unchanged in addition to FEV\(_1\). This study showed a wide range of dose equivalence values (3–13) depending on which parameter was analysed. Our data are compatible with a weight-for-weight dose ratio for salmeterol to salbutamol of ≤1:4 and a molar dose ratio of ≤1:3.8.

This is the first study to compare directly protection afforded by two doses of salmeterol and two doses of salbutamol. It agrees with the large multicentre clinical studies on which the clinically recommended therapeutic doses of salbutamol are based.\(^5\)\(^6\) These data should help to alleviate concerns regarding risks of salmeterol in the treatment of asthma proposed on the basis of previous high estimates of its relative β\(_2\)-agonist potency.


