Should You Use Budesonide-Formoterol As Needed for Mild Asthma - Frankly Speaking EP 83

Transcript Details

This is a transcript of an episode from the podcast series “Frankly Speaking” accessible at Pri-Med.com. Additional media formats for this podcast are available by visiting http://www.pri-med.com/online-education/Podcast/budesonide-asthma-frankly-speaking-83

Dr. Frank Domino:

John is a thirty-seven-year-old male who developed asthma as a teen. It rarely bothered him until about two years ago when he noticed he was having to use his rescue inhaler three to four times a week and would occasionally feel the need to use his rescue inhaler at night. I was treated with a daily inhaled corticosteroid twice a day, but didn't like the taste of it, so he stopped using it. Are there other options to help John with his asthma? Hi, this is Dr. Frank J. Domino, family physician and Professor in the Department of Family Medicine and Community Health at the University of Massachusetts Medical School. And here to discuss asthma with me today is Dr. Jill Terrien, Associate Professor and Director of Nurse Practitioner Specialties, at the University of Massachusetts Medical School's Graduate School Nursing. Thanks for coming, Jill.

Jill Terrien:

Thanks so much for having me, Frank.

Dr. Frank Domino:

So John's a real patient in my practice, and he does not like using his inhaled steroids.

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Jill Terrien:

So, in John's case is this a common problem that you see? But also, can you remind us about why you think John has some issues going on with his asthma? What kind of... What are the classifications?

Dr. Frank Domino:

So I think this is a good place to start. Intermittent asthma is all about less than two. It's symptoms less than two days a week, nighttime awakenings less than two times a month and short-acting beta-agonist use less than two days a week. So if you're having trouble remembering the classifications, remember intermittent is all less than two. Mild persistent asthma is symptoms greater than two. So, symptoms greater than twice a week, nighttime awakenings greater than two times a month and short-acting beta-agonist use greater than two times a week. Those are the most common classifications, the ones that we pretty easily manage. Moderate persistent are daily symptoms. People who have to feel the need that they need to use their beta-agonist on a regular basis every day, and have nighttime awakenings more than once a week. And severe persistent asthma, almost doesn't need definition.

You know these folks. These are people who have symptoms throughout the day, wake up every night needing to use their beta-agonist, and use their beta-agonist throughout the week, no matter what they do.

Jill Terrien:

So tell us a little bit about the study.

Dr. Frank Domino:

So this study looked at possibly trying to address John's specific issue. He's someone who

doesn't like using his inhaled corticosteroid every day. So this study looked at compared using an inhaled steroid twice a day to control the symptoms, versus using the combination budesonide and formoterol, as needed when he had symptoms. And they randomized, this was a study of adults, and they followed them forward. One of the unique things about this study was that the beta agonist that was used was not albuterol, but rather terbutaline, something we used to use in this country. And the study said, "Let's look at the most extreme case, to see if this intervention had any effect on that." And so they looked at the influence of these two interventions on the impact of severe exacerbations per year, and they made the cut off 1.2 severe exacerbations per year. And they were not trying to prove that one arm was better than the other, they were just trying to prove non-inferiority. Meaning that the new intervention was at least as good as the old interventions. They weren't trying to demonstrate things were hugely successful, they wanted to find if it was just as good.

Jill Terrien:

So Frank, just so you can clarify for me, when I think of mild persistent asthma, I don't always think of a severe exacerbation 'cause then I'm thinking hospitalization, I'm thinking risk of status asthmaticus, which is rare, but can be very life-threatening. So I'm just trying to weigh these two things. Mild versus something that's severe. And how this study informs us at all.

Dr. Frank Domino:

Jill, you've already pointed out one of the big flaws in the study. I think when we think of patients with mild persistent asthma, we assume that they're not going to have 1.2 severe exacerbations a year. They might have a winter time illness where we might need to treat with oral steroids, but we're not thinking about hospitalization or emergency room visits, or status asthmaticus. One of my big flaws with this study is that they chose an endpoint that

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was an extreme. If they chose refills on rescue inhaler use, or days they felt well or days they felt poorly, or something much more real world, it might have expanded my thoughts on this on trying this intervention. But they chose an extreme, and to prove non-inferiority for an extreme is pretty easy.

And so that was the outcome they chose. What they found was that there was no difference in severe outcome, severe exacerbations with the daily use of just the inhaled steroid versus the PRN use of the combination drug.

Jill Terrien:
So, here you have... So we've just talked about the study and we have John so are you... Are you likely to do anything differently with John?

Dr. Frank Domino:
Well, nothing would make me happier than be able to offer him a PRN treatment that's more effective than just a short-term beta-agonist. This study doesn't convince me that I'm ready to make that jump to this combination. I think if this study were repeated in a variety of populations, done by independent researchers and had those researchers do the data analysis; and if it still found that it was effective in changing real world patient outcomes, patient-oriented outcomes, I think I'd be happy to recommend it. So I look forward to this as maybe the first step in how we might change treating mild persistent asthma, but I'm not ready today to make this recommendation to him. I'll probably continue him on an inhaled corticosteroid, may be using a holding chamber, a spacer. I might inform him a little better. I might recommend, as you often suggest, doing peak flows and giving him some guidelines about a control program. I might see him up a little more closely. I might help identify what triggers have occurred in the last two years that have changed. Is he smoking? Does he have a pet? Does he live with someone who's possibly providing an

exposure risk, or is he doing something new for work that's possibly making matters different?

Jill Terrien:

Oh, like an environmental exposure.

Dr. Frank Domino:

Yes. But I'm not going to necessarily make this combination medication on a PRN basis, my next step in his care.

Jill Terrien:

That sounds good. Would you also think, Frank, do you use an app at all with your asthmatic's... About his symptoms? 'Cause you know, recall of how many times I'm doing things, what I was doing... You know, it's hard. We think that we know but you really, when you write it down, it puts it in black and white. So whether we use is paper and pencil or you have an app that he can log onto, to track his symptoms and possibly identify triggers. Something I find valuable in my population, if they wanna do it.

Dr. Frank Domino:

If they wanna do it. There are apps available and certainly keeping a written log... I think helping them do a peak flow in the office when they're not ill, and then saying, "Okay, you get below a percentage of this, you get down below 80% of your FEV1, I think we need to probably... I need to hear about it. If you're catching a cold or if the seasons are changing, you probably ought to at least consider coming in and being seen. I don't mind offering patients who have recurrent asthmatic exacerbations, if I feel like they're knowledgeable and trustworthy, giving them a prescription of oral steroids to take home and use when they feel symptoms coming on. I'd much rather do that than have them wait three or four

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days, come in when they've got all sorts of inflammation, and try to build back from there.

Jill Terrien:

Right. Well, thank you, Frank. It was an excellent review of that article.

Dr. Frank Domino:

Practice pointer: Mild persistent asthma is traditionally treated with a single preventative agent like an inhaled medium-dose corticosteroid used twice a day, every day. Join us next time when we begin the discussion of battling burn-out. And follow us over the next few months as we discuss concrete ways you can make changes that will improve your life. And for more timely relevant and practical medical education. Check out Pri-Med.com.

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