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Management of OCS Dependent Asthma

Announcer:

Welcome to CME on ReachMD. This activity, titled "Management of OCS-Dependent Asthma, is brought to you by CHEST and is supported by an educational grant from GlaxoSmithKline; and, Genentech, a member of the Roche Group.

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Here's your host, Dr. Sandhya Khurana, Professor of the Department of Medicine Pulmonary Diseases and Critical Care at the University of Rochester Medical Center.

Dr. Khurana:

Out of the approximately 334 million people worldwide who have asthma, 10% have or will progress to severe or uncontrolled disease, and among many of these patients, oral corticosteroid dependence becomes an unfortunate reality. Today we're going to focus on some of the common challenges encountered in managing oral corticosteroid-dependent asthma and consider strategies to improve care for this patient population.

This is CME on ReachMD, and I'm Dr. Sandhya Khurana. Joining me is Dr. Michael Wechsler, Professor of Medicine and director of the asthma program in the Division of Pulmonary Critical Care and Sleep Medicine at the National Jewish Health in Denver, Colorado.

Dr. Wechsler, welcome to the program.

Dr. Wechsler:

Thank you, Sandhya. It's great to be here today. Thank you for having me.

Dr. Khurana:

Great. Well, we're delighted to have you. So let's just dive right into the scope of this topic, Mike. How prevalent do you feel is the use of maintenance oral corticosteroids in patients with asthma? And why do you think physicians turn to this treatment option infrequently?

Dr. Wechsler:

Yeah, so, unfortunately, there's a fair amount of oral corticosteroid use, and despite the warnings and adverse events and concerns about oral corticosteroids, the number of prescriptions for oral corticosteroids have increased steadily over the last 20 years, particularly for those patients with severe asthma. And it isn't just short courses of corticosteroids. We know that in the US and in developing countries in Europe, there are over a million short courses of prednisone a year. What's most concerning to me is the wide prevalence of oral corticosteroids on a routine basis in the severe asthma population. And there have been reports from the Severe Asthma Research Program that as many as 32% of patients in that Severe Asthma Research Program received steroids for more than 50% of the year, and it's even higher in Europe. And we know from the British Thoracic Society that as many as 40% of patients in the British Thoracic Society Severe Asthma Registry have received regular prednisolone in doses of 10–15 mg a day, so I find that astonishing that in this day and age, particularly when we have biologic therapies available, that so much oral corticosteroids are being utilized given what we know about the potential effects of corticosteroids.

Dr. Khurana:

Thank you, Mike. Yeah, I agree. I think this is an area of concern amongst most of us. Are there doses or duration of corticosteroid therapy that you are particularly concerned about that are associated with toxicity? And when you're evaluating these patients, what are some of the toxicities that you are particularly concerned about?

Dr. Wechsler:

Yeah, so, I mean, there's a lot of toxicity from oral corticosteroids and their chronic use, and this ranges from cataracts and glaucoma to osteoporosis to hypercholesterolemia, but I think really what bothers patients the most is the frequency and occurrence of weight gain. That's the number one thing. They hate being on steroids because of that. And I'd say the second big thing is just the mood swings that people experience, the depression that patients experience while they're on corticosteroids. People get a little bit loopy and wacky when they're on them. Some people become hyperactive. Some people become more lethargic. You can see both extremes of sort of that mania and depression that can occur.

Dr. Khurana:

Yeah, it certainly has a very global effect, and there are, I know, a lot of efforts at corticosteroid stewardship that are being made. Can you speak about what's happening globally on that scale?

Dr. Wechsler:

Yeah, I think... So a lot of entities are working on oral steroid stewardship, and I think the big thing is to try to, first of all, recognize the problem and educate about the problem and educate people that maybe short courses of corticosteroids given frequently over the course of a year can be associated with these side effects and that there are alternative therapies that can be utilized for our patients with severe asthma, that you can give those patients new biologic therapies, that we can try to identify other comorbidities that are occurring that can be treated, that can prevent the utilization of oral corticosteroids. The problem is that people often don't recognize all those issues. And particularly when you move out of the specialty into primary care, it's just easy to give a short course of corticosteroids, and some people who are not in specialty practices, they may not recognize the utility of some of the newer therapies in terms of their capacity to reduce corticosteroid burden. So I think it's a multipronged approach that includes education as well as implementation, education about the side effects as well as education about the possibilities of what we can offer patients.

Dr. Khurana:

Yeah, it sounds like we really need an approach and buy-in from many different stakeholders to make dependence on oral corticosteroids go away.

For those just joining us, this the CME on ReachMD. I'm Dr. Sandhya Khurana, and today I'm speaking with Dr. Michael Wechsler about severe steroid-dependent asthma.

So, Dr. Wechsler, now that we have a better understanding of the challenges, let's move on to discuss how we can manage and support these patients and get them free of the oral corticosteroid dependence. Can you share your approach when you're evaluating and treating these patients? Are there any cases that you can share that come to mind that stand out to you?

Dr. Wechsler:

Yeah, so I think there are several steps that I take in my patients with severe asthma. The first step is, first of all, making sure that it is asthma, and that can be quite astonishing to some patients. I had a patient who recently came to see me in Denver, came from out of state, from Michigan, and had been on corticosteroids for the last decade or so for what was perceived to be severe asthma, and I did an extensive workup that included dynamic CT imaging and even bronchoscopy, and what we found in that patient was the patient had tracheobronchomalacia, and so, had airflow obstruction. It was dynamic in that it wasn't actually due to asthma, and the steroids may have actually been causing more of a problem in that patient. We stopped the corticosteroids and slowly tapered—the patient had been on them for a long time—and we added some positive pressure, among other things, and the patient did well. He was able to lose weight and come off of corticosteroids. So the first step is: Is this asthma? And that can be sometimes challenging because people who are on corticosteroids you don't necessarily see the bronchodilator reversibility.

The second component is identifying are there comorbidities that could be occurring that could be contributing to what was perceived to be severe asthma but is actually some of the comorbidities, so to what extent is there significant reflux disease, significant sinus disease, significant respiratory tract infection or vocal cord dysfunction that could be contributing, so that's the second component. Often times, if you address those comorbidities, then the patient may get better and may not require the same degree of corticosteroid burden.

The third piece can be done at any point, and that is addressing inhaler technique and also evaluating for adherence. Are the patients taking their medications as they are recommended? We have all seen a number of patients, if you ask them to show you how they use their inhalers, that they may not be doing things as correctly as they might otherwise be, so reteaching that.

And then the last piece is to identify what type of asthma does the person have, and that involves doing a bit more evaluation of phenotypic characterization and an endotyping characterization, so if the patient has type 2 asthma and may respond to one of the biologics that we have, anti-IgE, and IL4, 13, or anti-IL5, or if the patient has a non type 2 asthma and may not benefit from any of those, may not even benefit from the corticosteroids they're on and we need to consider alternate therapy like bronchial thermoplasty or chronic azithromycin or something along those lines.

So that's my general approach in terms of attacking the problem and getting people off of corticosteroids. And part of that also involves a multidisciplinary approach, a team-based approach, which I know you wanted to talk about as well, and that involves working with other specialists that may have some insight into what those comorbidities are, whether it's the ENT doctors, whether it's the GI doctors, whether it's the allergists and/or the pulmonologists depending on what sphere you're in, and also working with nurses and nurse educators in terms of providing the necessary education to our patients in all those realms.

I can think of so many patients who've benefitted from this multipronged approach, this team approach, and I think if you implement most of these strategies, you should have some success, and we've had success in terms of reducing the number of patients who are corticosteroid-dependent in our practice using these kinds of strategies.

Dr. Khurana:

Thank you. The partnership with endocrine colleagues and other specialists is key. Do you usually get them involved early in the course when you get involved in care of these patients?

Dr. Wechsler:

Yeah, usually it depends on—it depends on how often patients have tried to get down, how long they have been on corticosteroids, but if patients have been on for several months or more, I get them involved early. If patients have had some difficulty tapering in the past, I get them involved early. Sometimes some patients benefit from alternate types of corticosteroids, so instead of prednisone, going on methylprednisolone or hydrocortisone, and some patients may benefit from the different steroid properties, and in some cases it may be an issue of steroid pharmacokinetics and pharmacodynamics even given individual. At our institution, at National Jewish, we actually have the capacity to do some of those steroid pharmacokinetic and pharmacodynamic studies, so that helps a little bit. That isn't available in most places, however.

Dr. Khurana:

Right. And just coming back to the team-based approach that you mentioned, could you share the strategies? Do you have strategies that you've incorporated to ensure that the team is coordinating the care effectively? Is there a navigator on board, or how do you get the patient through the process?

Dr. Wechsler:

Yeah, so I think the most important aspect of that is just good communication and having communication between providers and making sure that the goals of care are understood and what's possible is understood by both the patient as well as by the whole team of providers, so I think the most important thing is just good communication. I actually find it more effective to pick up the phone rather than just sending a copy of my note over to another doctor just to make sure that everyone is aligned, and I think patients appreciate that, and most physicians appreciate it. If they have the time, most are willing to pick up the phone, actually, and have that type of conversation about what the goals of care are and how we plan to implement the strategies to effectively manage the patient.

Dr. Khurana:

Unfortunately, we're almost out of time, but before we go, Dr. Wechsler, if you could give us one call to action for your colleagues who are treating patients with OCS-dependent asthma, what would that be?

Dr. Wechsler:

Yeah, so I think it's so important to recognize all of the issues associated with oral corticosteroid-dependent asthma. I think it's important for us to educate about those morbidities and to really try to get people off of oral corticosteroids using the stepwise approach of evaluating if it's asthma, evaluating for comorbidities, evaluating the endotype and phenotype of the patient, and offering therapeutic strategies that work in a collaborative, team-based approach. So I know there's a lot in there. I packed a lot of information into that calls to action, but really, in 2020 and beyond, we should not be using oral corticosteroids for the majority of our patients, for the vast majority of our patients with asthma, and our goal should really be to eliminate oral corticosteroids and their toxicity from our patients with severe asthma. We have great other options now, and we should try to avail ourselves of those options.

Dr. Khurana:

Thank you. Well, with those takeaways in mind, I want to thank my guest, Dr. Michael Wechsler, for helping us better understand both the challenges and some strategies towards managing patients with steroid-dependent asthma. Mike, it was great speaking with you

today. Thank you.

Dr. Wechsler:

Thank you, Sandhya. It was great talking to you as well. Stay safe.

Announcer:

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