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New Considerations for Step-Up Treatments in Asthma Patients

Announcer Introduction:

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And, here is your host Dr. Tom Corbridge, who is an Emeritus physician and Adjunct Professor of Medicine at Northwestern in Chicago, IL. And, a respiratory medical expert in US medical affairs at GlaxoSmithKline.

Dr. Corbridge:

There are approximately 25 million Americans with asthma,¹ and of those, close to 62 percent have uncontrolled asthma,² which can take a heavy toll on patients' health and quality of life.³ While maintenance use of an inhaled corticosteroid combined with a long-acting beta agonist is still one of the cornerstones of therapy, the emergence of long-acting muscarinic receptor antagonists, or LAMAs, may be changing how we approach step-up treatment for some patients.⁴ On today's program we'll explore this development.

Welcome to *Deep Breaths: Updates from CHEST* on ReachMD. My name is Dr. Tom Corbridge, and joining me today is Dr. Navitha Ramesh. Navitha is a pulmonologist and critical care physician at UPMC Pinnacle in Harrisburg, Pennsylvania, which is actually a new position for her. And, Navitha, I'd like to welcome you to the program.

Dr. Ramesh:

Hello, Dr. Corbridge. Thank you so much for having me here with you today.

Dr. Corbridge:

It's a pleasure. So, Navitha, let's jump right into our case, which focuses on a 55-year-old woman with asthma of 20 years duration. She's a lifetime nonsmoker. She has chronic rhinosinusitis and gastroesophageal reflux disease. Her occupational and environmental exposures have included exposure to dust and chemicals—this was years ago while she worked in a factory making towels—and living in a damp basement until 5 years ago. She has no pets. She has required rare bursts of prednisone but has never been treated in an ED or hospital. She currently states that she feels pretty good. Medications include a short-acting beta agonist for rescue, which she takes every other day, and a medium-dose ICS combined with a LABA. Notable exam findings include a BMI of 38 and faint expiratory wheezes bilaterally. Recent spirometry shows an FEV1 of 68 percent of predicted with a positive bronchodilator response.

So, Navitha, how would you assess this patient if you were to see her today in your clinic?

Dr. Ramesh:

Sure, Dr. Corbridge. We know that patients with asthma, usually underreport their symptoms and the level of control,⁵ so I would like to start by asking specific questions about her symptomatology and level of activity.⁴ Also, I would like to use a validated tool, such as an Asthma Control Test, which is very helpful to categorize the patients who have asthma.⁶ Based on what you have told me so far, this patient has been overusing her rescue medication, which by itself is a marker for uncontrolled asthma.⁴ So at first I would start by reviewing her environment, both her home environment and her work environment, adherence to inhalers, her inhaler techniques; then I would like to assess and address her comorbidities and also make sure that she's up-to-date with all her vaccinations. Once that's done

I would like to phenotype this patient into T2-high asthma or T2-low by performing blood eosinophil levels, IgE, and also checking her exhaled nitric oxide levels.

Dr. Corbridge:

There's a lot of work to do, but I'm really glad that you mentioned that you needed to carefully assess her control because so many people do overestimate their level of control.⁵ Well, if we assume that she's adherent and has proper inhaler technique and, as you said, has uncontrolled asthma, what does the Global Initiative for Asthma, or GINA 2020, strategy recommend regarding step-up therapy for a patient like this?

Dr. Ramesh:

So this patient is clearly a candidate for step-up therapy per GINA⁴. We could increase her inhaled corticosteroid dose while continuing her LABA, or we could also consider adding a LAMA to her current regimen. So GINA supports the use of LAMA in both step 4 and step 5, which is adding LAMA to a medium-dose inhaled corticosteroid/LABA combination as part of step 4 and also as a triple therapy, which contains a high-dose ICS + LABA as well as LAMA as part of step 5. Similar to LABA use, LAMA should never be used by itself in a patient with asthma without the use of a concurrent ICS.

Dr. Corbridge:

So, do we have data supporting the addition of a LAMA to a patient who is receiving, let's say, a medium-dose ICS+LABA inhaler combination?

Dr. Ramesh:

We definitely have data that supports the use of LAMA as an add-on therapy in patients with uncontrolled asthma.^{4,7} LAMA can be used as an add-on to both medium-dose ICS+LABA combination and also to high-dose ICS+LABA combination. Addition of LAMA decreases the risk for exacerbation, improves the lung function, and also improves asthma symptom control in these patients.

Dr. Corbridge:

You mentioned earlier that you would want to phenotype this patient. How would that affect your management? And specifically, do LAMAs have efficacy in both patients with T2-high and T2-low asthma?

Dr. Ramesh:

That's a great question, Dr. Corbridge. The available data we have so far indicates that a LAMA can be used and is beneficial in both T2-high as well as T2-low asthma patients,⁸ so that's why it's always important to phenotype the patients with asthma to help individualize the treatment regimen.⁴ For instance, if a patient has T2-high asthma, these patients are generally more responsive to inhaled corticosteroids,^{9,10} and they may be candidates for biologic therapy as well,⁴ so it's always good to categorize these patients into these 2 phenotypes.

Dr. Corbridge:

Thank you. So, kind of a timely question: Given that we're in the middle of the COVID-19 pandemic, what advice are you giving your patients about the use of their inhalers—or any other advice that you may be giving them right now?

Dr. Ramesh:

Regarding COVID-19 and asthma, our knowledge of this topic is still evolving. We don't have a lot of data yet. However, based on the guidance that GINA has given us, my recommendation to my asthma patients would be to continue the inhalers, which is both the controllers as well as the rescue inhalers, especially continue using the inhaled corticosteroids, and if the patients are on baseline biologics or if they are on oral steroids, I would recommend they continue those as well.⁴ The key point here is to help these patients maintain adequate asthma control so they don't go to the emergency room or to the hospital with acute exacerbation. And it's always important to remember that maintaining strict infection control measures is of utmost importance, especially during this COVID pandemic.¹¹

Dr. Corbridge:

So, before we wrap up, Navitha, do you have any other thoughts or takeaways that you would like to leave us with today?

Dr. Ramesh:

I would like to reiterate that LAMA use improves asthma function in both T2-high and T2-low asthma patients who are already on an ICS+LABA combination despite which they have poor symptom control or poor lung function.^{9,10} Per GINA guidelines,⁴ add-on LAMA therapy should be done on patients when appropriate. And, you know, the key with LAMA use is it improves outcome measures, such as peak flow variability, subjective asthma control and quality of life, spirometry, as well as decreased risk for asthma exacerbations.⁷

Dr. Corbridge:

Well, thank you, and what a great way to tie this all together. And with those closing thoughts, I want to thank you so much for joining me today to discuss the role of LAMAs for patients with uncontrolled asthma. It was great having you on the program.

Dr. Ramesh:

Thank you so much for having me here, Dr. Corbridge.

Announcer:

This was *Deep Breaths: Updates from CHEST* produced in partnership with the American College of Chest Physicians. To access other episodes of this series, visit ReachMD.com/CHEST, where you can be part of the knowledge. Thanks for listening!

References:

1. Centers for Disease Control and Prevention. Most Recent Asthma Data. Available at: https://www.cdc.gov/asthma/most_recent_national_asthma_data.htm. Accessed July 14, 2020.
2. Centers for Disease Control and Prevention. Uncontrolled Asthma among Adults, 2016. Available at: https://www.cdc.gov/asthma/asthma_stats/uncontrolled-asthma-adults.htm. Accessed July 14, 2020.
3. Centers for Disease Control and Prevention. Uncontrolled Asthma among Persons with Current Asthma. Available at: https://www.cdc.gov/asthma/asthma_stats/uncontrolled_asthma.htm. Accessed July 14, 2020.
4. GINA: Global Strategy for Asthma Management and Prevention 2020. Available from: https://ginasthma.org/wp-content/uploads/2020/06/GINA-2020-report_20_06_04-1-wms.pdf. Accessed July 14, 2020.
5. Alzahrani YA and Becker EA. *Respiratory Care*. 2016;61:106-116.
6. Nathan RA et al. *J Allergy Clin Immunol*. 2004;113:59-65.
7. Kerstjens HA et al. *Lancet Respir Med*. 2015;3:367-376.
8. Casale TB et al. *J Allergy Clin Immunol Pract*. 2018;6:923-935.
9. Fahy JV. *Nat Rev Immunol*. 2015;15:57-65.
10. Coverstone AM et al. *J Allergy Clin Immunol Pract*. 2020;8:442-450.
11. Centers for Disease Control and Prevention. Coronavirus Disease 2019 (COVID-19). Available at: <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/asthma.html>. Accessed July 14, 2020.