BTS/SIGN Guidelines - Query for Committee

Sir,

We recently received this query on which the GPIAG may be able to proffer an opinion.

" I have been unable to clarify the situation of double dosing in the guidelines (BTS/SIGN). They state there is no evidence to support it and as a result don't recommend it. However, they strongly recommend self management plans, of which double dosing has been a fundamental part. Can you clarify the situation."

On speaking to the GP their basic need was to establish an alternative to the double dosing of inhaled corticosteroids, on exacerbation of asthma, if that could no longer be recommended in a self-management plan.

Clinical Information Analyst
ATTRACT
(a query answering service run for GPs in Wales)
Prim Care Resp J 2003; **12(2)**:71

My personal opinion:

The principle of SMPs is to advise patients to adjust their medication when their asthma goes out of control. This includes increasing current medication (inhaled steroids and short or long acting beta agonists)or adding new medication (mainly oral steroids).

It is well known that inhaled steroids reach a plateaux in their dose response curve. The problem is that different inhaled steroid/device combinations have differing potencies (well demonstrated by researchers at the National Jewish Hospital in the USA, presented at the recent American Thoracic Society meeting by Monica Kraft). Therefore, increasing inhaled steroids dose will help those patients who have not reached the plateaux dose of their particular inhaled steroid and this is a common situation reported anecdotally. For these and other reasons, the beneficial effect of SMPs, involving doubling doses of steroids is very difficult to prove. However, as Martin Bland has always said, absence of evidence does not mean there is no evidence. There are a few studies which demonstrated the efficacy of SMPs, most cited in the SIGN guidelines (including one of my own studies (Levy *et al*, Resp Medicine Sep 1999). I did show that high doses of inhaled fluticasone was as effective as oral steroids in acute asthma in primary care (Levy *et al* Thorax, 1996) and a number of researchers, Mitchell in particular (ERS 1996), showed benefit from nebulised inhaled steroids in A&E in Australia.

While the increased doses, during exacerbations, should theoretically be determined for each and every patient, this is not practical in my view. Therefore, it is expedient to advise patients to double or increase their inhaled steroids when their asthma goes out of control, monitor their PEF response to this treatment and resume their usual dose when better. This works fine for me and I think my patients benefit from this advice.

Dr Mark L Levy, Editor
Prim Care Resp J 2003; **12(2)**:71

Sir,

Thank you for your query. BTS and SIGN are aware of the confusion about 'doubling inhaled steroids and there is talk of introducing some practical guidance about these sort of issues. In the meantime I hope the following clarifies the issues.

As you rightly say self-management plans, which include 'doubling inhaled steroids', have been shown to work and are strongly recommended.

Trials which try to dissect individual components of self-management plans tend to give conflicting results - the bottom line is that self-management is on-going multi-faceted education process which facilitates a change in behaviour, and may include a whole range of actions.

Many of the high quality studies of self-management plans have been undertaken in secondary care patients in whom it easier to demonstrate change - but a group for whom the provision of oral steroids is likely to be more important than increasing inhaled steroids.
There is an excellent study [Foresi A, Morelli MC, Catena E. Low dose budesonide with the addition of an increased dose during exacerbations is effective in long term asthma control. *Chest* 2000; **117(2)**:440-6] which compares three groups: 200mcg budesonide vs 800mcg daily vs 200mcg budesonide + an increase to 800mcg with exacerbations. The 200+800mcg group had as good control as the 800mcg group - and better than the 200mcg group. On the basis of this I am now preaching 'increase to 800mcg' rather than 'double' inhaled steroids. This was included in the earlier drafts of the guidelines - I suspect it was edited out by secondary care colleagues (see preceding point!)

The guidelines recommend the use of the National Asthma Campaign's self-management plan (or Action Plans as we have to call them now) These include a step for increasing inhaled steroid when peak flow falls below 80% of best or when symptoms recur. I normally advise increasing (or recommencing if the patient has defaulted from taking them!) inhaled steroids to a dose of to 800 - 1,000mcg daily. Patients who are already on 800mcg a day, by definition moderate to severe asthmatics, will probably not gain sufficient benefit from increasing the dose further and should be a advised to start oral steroids.

We really need a well designed pragmatic RCT of self-management plans in the mild - moderate patients that we see in primary care. Then we will not need to go on protesting that 'absence of evidence' is not the same as 'evidence of absence'

Dr Hilary Pinnock
GPIAG Committee Member *Prim Care Resp J* 2003; **12(2)**:71

Sir,

I find the issue confusing and not as clear cut as others make out.

We all agree that asthma is under-treated, many patients suffer symptoms unnecessarily and that many severe exacerbations and admissions are avoidable.

I think we under-estimate the vast amount of time and energy that many practice nurses devote to making sure patients know how to step up their treatment, usually concentrating on doubling the inhaled steroid dose. This time can be better spent.

I contend that any increase in symptoms or fall in lung function is due to poor chronic control of the asthma. The reasons for this should be addressed, and (usually) chronic treatment should be increased and remain at the higher levels indefinitely. Any exacerbation is a failure of management, and we should stop looking on asthma as a disease which invariably requires variable treatment - in effect what we are saying is that it is OK for your asthma treatment to keep you on the brink of long-term control, and it is OK to lose control from time to time, and to regain control by temporarily increasing your preventative treatment.

SMPs are undoubtedly necessary for a minority of asthmatics whose disease is very variable in severity, but should not be needed for the