Inhaler devices for the treatment of asthma and chronic obstructive airways disease (COPD)

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The research evidence on the effectiveness of inhaler devices for the treatment of asthma and chronic obstructive pulmonary disease published in a recent issue of Effective Health Care is reviewed.

This article summarises the research evidence presented in a recent issue of Effective Health Care on inhaler devices for the treatment of asthma and chronic obstructive airways disease (COPD).1

BACKGROUND

Inhaled therapy delivering bronchodilator and corticosteroid drugs in various doses has become accepted as the mainstay of treatment for patients with asthma and chronic COPD.2,3 It allows low doses of medication to be delivered directly to the site of action in the airways, significantly reducing systemic side effects compared with oral therapy. The aim of inhaled therapy is to reverse and prevent airway inflammation and constrict and minimise symptoms. The two main categories of inhaled drugs are bronchodilators and corticosteroids. Bronchodilators (short and long acting β2 agonists and antimuscarinic drugs) relieve symptoms of bronchoconstriction. Corticosteroids reduce airways inflammation to prevent symptoms of asthma.

A number of different inhalation devices are available. The pressurised metered dose inhaler (pMDI) is the most commonly used and cheapest device, which may also be used in conjunction with a spacer device. Newer chlorofluorocarbon (CFC)-free inhaler devices using hydrofluoroalkanes (HFAs) have also been developed. The drug is dissolved or suspended in the propellant under pressure. When activated, a valve system releases a metered volume of drug and propellant. Spacer chambers can be attached to pMDIs to make them easier to use.

Other devices include breath actuated pMDIs such as Autohaler and Easibreathe. They enable the patient to prime the inhaler which is then only actuated when the patient takes a breath, avoiding the need to coordinate actuation with breathing. Dry powder inhalers (DPI) such as Turbohaler, Diskhaler, Accuhaler and Clickhaler are also activated by inspiration by the patient. The powdered drug is dispersed into particles by the inspiration.

Nebulisers use oxygen, compressed air, or ultrasonic power to break up solutions or suspensions of medication into droplets for inhalation. The aerosol is administered by a mask or mouthpiece. However, nebulisers are more expensive than pMDIs, require a power source, and need regular maintenance.

There is a confusing array of inhaler devices available for the treatment of asthma and COPD. The competing claims of pharmaceutical companies make it difficult for prescribers to choose the best device for different patients. This article summarises the current research evidence on the clinical and cost effectiveness of these pMDIs (with or without a spacer device) compared with other hand held inhaler devices. It updates the evidence from a number of systematic reviews carried out by the Cochrane Airways Group and funded by the NHS Health Technology Assessment Programme.4 The original reviews were used as supporting evidence for two technology appraisal guidance reports for the National Institute for Clinical Excellence5,6 and for forthcoming guidance from the British Thoracic Society. Details of the additional randomised controlled trials (RCTs) included in the update can be found in table 1.

RANGE AND COSTS OF DRUGS AND DEVICES

The annual cost to the NHS for asthma drugs is over £500 million.7 A large number of inhaler devices and drug/device combinations are commercially available. There are considerable differences in the costs of the same drug using different inhaler devices and of the drugs used in specific devices.8 The use of a specific inhaler device may limit prescribing choice to more expensive proprietary drugs. In addition, some inhaler and drug combinations are limited by commercial availability.

Clinical guidelines on the use of inhalers for asthma and COPD have been published from a number of sources.2,3,9,10 However, the recommendations for inhaler devices from these guidelines are either absent, vague, or inconsistent. Evidence based guidelines are currently being developed by the British Thoracic Society.

EFFECTIVENESS OF HAND HELD INHALER DEVICES FOR ASTHMA

Delivery of corticosteroids in stable asthma

Three studies in children comparing different devices failed to show significant differences in pulmonary function between the devices.11–13

Three further studies in children were identified,14,15 but the heterogeneity of the original studies precluded any pooling of results. This remains the case with the addition of the new studies. Farmer et al.16 studied 229 children with asthma aged 7–12 years and compared a CFC and
Table 1: Additional randomised clinical trials included in the Effective Health Care update

<table>
<thead>
<tr>
<th>Study</th>
<th>Methodology</th>
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<tr>
<td>Crompton40</td>
<td>Design: parallel open Device: pMDI+Nebuhaler v Turbuhaler Drug: budesonide Dose: “usual dose” Duration: 12 weeks</td>
<td>Participants: 72 asthmatics, mean age 47. Mean FEV1 % predicted, 68%</td>
<td>4-point dysphonia score reported. FEV1 and FVC measured but only reported “no significant change in either group”. Other non-clinical outcomes measured (laryngoscopy, voice analysis)</td>
<td>72 randomised, 64 completed and 51 “considered evaluable for per protocol analysis”. Specifically designed to identify voice changes rather than asthma control.</td>
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<td>Farmer41</td>
<td>Design: Parallel, double blind Device: HFA v CFC Easibreathe breath actuated pMDIs Drug: Beclomethasone Dose: 200 µg daily Duration: 12 weeks</td>
<td>Participants: 229 asthmatics aged 7–12, 199 supplied evaluable data. Mean FEV1 % predicted, 80% predicted</td>
<td>No significant differences in diary card PEFR, FEV1, symptom scores, adverse events, serum cortisol from 19% of the population Authors’ power calculation shows this to be underpowered to demonstrate equivalence</td>
<td>Primary outcome was air trapping as measured by CT imaging. This is non-clinical and was not included in this analysis</td>
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<td>Goldin41</td>
<td>Design: Parallel, double blind, double dummy Device: CFC v HFA pMDI Drug: Beclomethasone Dose: 200 µg daily Duration: 12 weeks</td>
<td>Participants: 34 asthmatics aged 19–56 years. Mean FEV1 80% predicted</td>
<td>Diary card PEFR, symptom scores and β-agonist use, FEV1, methacholine challenge Primary outcome was air trapping as measured by CT imaging. This is non-clinical and was not included in this analysis</td>
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<td>Juniper42 (see also Gross77)</td>
<td>Design: Parallel, single blind Device: HFA v CFC pMDIs Drug: Beclomethasone Dose: 400 µg v 800 µg daily Duration: 12 weeks</td>
<td>Participants: 347 moderate asthmatics (162 M, 185 F), mean age 33 (3rd arm of 117 patients received HFA placebo)</td>
<td>Asthma quality of life questionnaire, daytime symptoms and sleep disturbance scores</td>
<td>Supplementary report of results to Gross.77</td>
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<td>Pearlman43</td>
<td>Design: Parallel, double blind Device: HFA v CFC pMDIs Drug: Triamcinolone Dose: 150, 300 and 600 mg daily, 6 arms Duration: 12 weeks</td>
<td>Participants: 473 children aged 6–13 years enrolled, 374 completed</td>
<td>% change FEV1, change in β agonist use, FEV1, PEFR, night time waking, symptom scores, adverse events</td>
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<td>Rufin44</td>
<td>Design: Parallel, open trial Device: pMDI+spacer v Autohaler Drug: Beclomethasone Dose: 1000 µg daily Duration: 8 weeks</td>
<td>Participants: 127 asthmatic children 5–15 years old, mean age 11</td>
<td>PEFR (am, pm), daytime, night time symptom scores (FEV1, FVC only reported “non-significant”), exacerbations, adverse events, serum cortisol Unclear if ITT analysis used</td>
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<td>Stradling45</td>
<td>Design: Parallel, double blind, double dummy Device: pMDI+spacer v Clickhaler Drug: Beclomethasone Dose: “usual” dose Duration: 8 weeks</td>
<td>Participants: 240 asthmatics entered run in, 204 randomised. Mean age 50 years</td>
<td>PEF (am, pm), daytime, night time symptom scores (FEV1, FVC only reported “non-significant”), exacerbations, adverse events, serum cortisol Unclear if ITT analysis used</td>
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<td>Maladano-Alanis46</td>
<td>Design: 3 way parallel, open study Device: pMDI + PulmoNA spacer v pMDI + Ellipse v Hudson nebuliser Drug: Salbutamol Dose: 200 µg v 200 µg v 150 µg/kg Duration: 6 hours</td>
<td>Participants: 63 asthmatic children aged 6–15 years.</td>
<td>FEV1, at 5, 20, 60 minutes and 2, 3, 4, 5, 6 hours. Reported equal at 1 hour [24% increased] but at 6 hours the nebuliser had decreased least [15.5 v 14.7 v 5.5%]</td>
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<td>Salzman47</td>
<td>Design: Crossover, open trial Device: pMDI+spacer v Hudson Updraft II nebuliser at 6 l/min Drug: Metaproterenol Dose: 1.3 v 15 mg Duration: 2 x 1 day</td>
<td>Participants: 15 adult severe asthmatics, 18–47 years</td>
<td>Mean % increases in FEV1, FVC, PEFR, MMFR, PEF12–75%</td>
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HFA EasiBreathe (breath actuated inhaler) delivering beclomethasone dipropionate. No differences were found in diary card peak flow expiratory rate (PEFR), forced expiratory volume in 1 second (FEV1), symptoms scores, adverse events, and serum cortisol levels from 19% of the population. Four further studies have since been identified. 20–23 The addition of data from these four studies to the original meta-analysis made no significant change to the results. For the delivery of inhaled steroids in stable asthma in children over 5 years and adults, pMDI (with or without spacer) is as effective as other hand held inhaler devices. There is no evidence to demonstrate differences in drug delivery between non-CFC pMDI and CFC pMDI at equivalent doses.

Delivery of short acting β₂ agonist bronchodilators in chronic asthma

A Cochrane review and meta-analysis of 84 RCTs found no differences between pMDI and 10 other hand held inhaler devices for lung function, blood pressure, symptoms, bronchial hyperreactivity, systemic bioavailability, inhaled steroid requirement, serum potassium, and use of additional relief bronchodilators. 41 In addition, no evidence was found to support claims that higher dosing schedules (2:1 or greater) had any clinical advantage over 1:1 dosing. Regular use of HFA-pMDI containing salbutamol reduced the requirement for short courses of oral corticosteroids. These data were provided by three trials with a total of 519 patients (fig 2). 44, 45 However, the total number of exacerbations in these three trials was unchanged. The effect of HFA-pMDI on requirement for oral corticosteroid courses to treat acute exacerbations therefore needs to be confirmed.

Three trials in adults found a lower pulse rate in patients using pMDI than those using Turbhaler, suggesting greater

Figure 1 Absolute difference in FEV₁ between pMDI and dry powder inhaler (DPI) for the delivery of corticosteroids in stable asthma (Z statistic [2.23] indicates the level of significance for the overall result).

Figure 2 Short course oral corticosteroid requirement for acute exacerbations in adult patients with asthma. Data from three long term parallel design trials (represented as relative risk calculated using fixed effect model with 95% confidence intervals; Z statistic (2.58) indicates the level of significance for the overall result).
systemic absorption with the Turbhaler device compared with the pMDI (fig 3).

Three studies found that adult patients preferred pMDI to the less commonly used Rotahaler device (fig 4). However, this result should be interpreted with caution because of the potential for bias due to lack of blinding.

For the delivery of inhaled short acting β₂ agonists in chronic asthma, pMDI (with or without spacer) is as effective as any other hand held inhaler device.

**CLINICAL EFFECTIVENESS OF HAND HELD INHALER DEVICES FOR COPD**

A Cochrane systematic review compared pMDI with other devices. No significant difference in clinical outcomes was found between dry powder devices and pMDI for delivery of β₂ agonists. A soft mist device for ipratropium (Respimat) was more effective than a pMDI in improving lung function but as any other hand held inhaler device.

**EFFECTIVENESS OF NEBULISERS**

**Chronic asthma**

Three studies in children totalling 51 participants compared different hand held inhaler devices with a nebuliser and found no evidence of clinical superiority of nebulisers over inhaler devices. Twenty three studies in adults showed clinical equivalence for inhaler devices and nebulisers for the main pulmonary outcomes (FEV₁, and PEFR) and no evidence of significant difference in other outcomes.

Figure 5 shows the standardised mean difference of FEV₁ between nebulisers and hand held inhaler devices for the delivery of β agonists in stable asthma.

Updated searching identified two further studies. Maldonado-Alanis et al evaluated the bronchodilator response of 63 children over 6 hours in a three way parallel study. The results were published as an abstract only and detailed statistical results were not shown. The initial bronchodilator response for salbutamol was similar between pMDI+Pulmona spacer, pMDI+Ellipse spacer (200 µg from each) and a nebuliser (at a dose of 150 µg/kg).

Salzman and Pyshcznki included 15 patients with severe stable asthma in a 2-day open crossover trial of metaprotocol 1.3 mg via pMDI+Aerosol spacer device versus 15 mg via a nebuliser. No statistically significant differences in expiratory airflow were found between the delivery methods.

**Acute asthma**

A Cochrane systematic review of 16 trials comparing pMDI+spacer with nebulisers for the delivery of β₂ agonists for mild and moderate exacerbations of asthma found that clinical outcomes from pMDIs were at least equivalent to nebulisers and may have some advantages for children. Children over 5 years and adults with mild and moderate exacerbations should be treated with pMDI+spacer with bronchodilator dose titration according to clinical response.

**COPD**

Thirteen trials have compared bronchodilator drugs delivered by inhaler devices compared with nebulisers for the treatment of patients with acute and stable COPD. There was considerable variation in settings and the drugs and delivery devices used, making comparisons difficult. However, a meta-analysis supported the findings of individual studies that there is no evidence to suggest clinical benefit of nebulisers over a standard pMDI with spacer, although a higher dose may be required.

**INHALER TECHNIQUE**

The effectiveness of inhaler devices depends on more than just the devices themselves. Patient technique is crucial to effective drug delivery and will depend on factors such as patient experience, education, physical ability, and effective teaching of technique.

A systematic review of RCTs and observational studies supports the anecdotal impression and prejudice that pMDI devices are not used as effectively as dry powder inhalers. The percentage of patients with correct technique (assessed by a scoring system of correct steps) was 43% compared with 55% for pMDI with spacer and 59% for dry powder inhalers. However, teaching had a positive effect and eliminates significant differences between devices by increasing the percentage of patients with correct technique to 63% for pMDI and 65% for dry powder inhalers.

Differences in effective patient technique therefore appear to owe more to the lack of teaching than to inherent differences in the devices themselves. All patients should receive appropriate instruction and guidance on effective technique when prescribed inhaler devices, and this should be regularly reinforced.

**IMPLICATIONS**

This article is based on systematic reviews that report average clinical effects from the trial results across drugs, doses, and devices. It may well be that, just as individual patients receive a dose tailored to their needs, they also receive devices tailored to their individual needs. However, on the basis of the available evidence, there is no reason to expect alternative inhaler
devices to be clinically more effective than pMDIs (with or without a spacer) for delivery of short-acting β bronchodila-
tors or corticosteroids, pMDIs (with or without a spacer), or the cheapest inhaler device the patient can adequately use, should therefore be prescribed as first line in all adults and children with stable asthma or COPD requiring inhaled medication. More expensive devices such as dry powder inhalers should be reserved for patients who do not have the technique or coordination to use pMDIs effectively after appropriate teaching.

Further high quality RCTs are required to be able to make valid recommendations on the use of the various inhaler devices available for the treatment of asthma or COPD. This is of particular importance because of the phasing out of CFC propellants in pMDIs. Studies should be of sufficient duration to be clinically relevant and with medication doses that are clinically appropriate. They should be undertaken in real life community setting to ensure generalisability of results.

At present the introduction of a new device for the delivery of inhaled drugs needs far less rigorous testing than for a new drug by an old device. The licensing requirement is to demonstrate equivalence to an existing device. Equivalence is not the same as failing to detect a difference, and the design and powering of trials is specific and not without controversy. It may be that stricter controls are needed before approval.

Given the chronic nature of asthma and COPD and their significant effects on morbidity, future trials should address the paucity of patient centred outcomes such as quality of life, adherence, nocturnal awakening, and days off work or school. In addition, adverse effects and systemic effects should be recorded more completely. If devices share equivalent effectiveness, then secondary factors such as adverse effects become much more significant.

The teaching of inhaler technique is another important area for future research. Studies should explore the effectiveness and frequency of patient education and consider interventions to improve it. In addition, studies of teaching of inhaler technique should measure health related outcomes as the relationship between inhaler technique and clinical outcome has not been established.

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