

Large Study Links Rhinitis to Adult-Onset Asthma

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Rhinitis was a strong predictor of adult-onset asthma, according to findings from an 8-year population-based study in Europe.

In the European Community Respiratory Health Survey, data from 6,461 participants showed that allergic rhinitis was associated with an increased risk of adult-onset asthma (adjusted relative risk of

3.53), as was nonallergic rhinitis, although to a lesser degree (adjusted relative risk of 2.71). Dr. Rafea Shaaban of Bichat Teaching Hospital, Paris, and colleagues reported.

The subjects were aged 20-44 years without asthma at baseline. They were categorized into four groups: a control group including 3,163 subjects with no atopy and no rhinitis, an atopy-only group including 704 subjects with atopy but no rhinitis, a non-allergic rhinitis group including 1,377 sub-

jects with rhinitis but no atopy, and an allergic rhinitis group including 1,217 subjects with atopy and rhinitis.

A total of 140 subjects developed asthma during the 8.8-year study period, for a cumulative incidence of 2.2%. The incidence in the groups was 1.1%, 1.9%, 3.1%, and 4.0%, respectively. The differences were statistically significant, but only allergic rhinitis in those identified by a skin-prick test as having dust mite sensitization was found to be associated with increased

risk of asthma independently of other allergens (Lancet 2008;372:1049-57).

A possible explanation for the dust mite link, the investigators said, is that patients with allergic rhinitis in response to mites are likely to have nasal symptoms over a longer period of time, because mites are a perennial indoor allergen. That theory is consistent with the findings of at least one other study showing that early exposure to dust mite allergen is associated with an increased risk of childhood asthma.

Sensitization to allergens in addition to mites was associated with additional small increases in asthma risk. For example, in those sensitized to dust mites, sensitization to cats increased asthma risk from 4.6% to 6.4%, and sensitization to grass increased the risk to 7.6%. Sensitization to birch increased the risk to 9.1%.

Those increases did not reach statistical significance, but that may be because of the small number of patients with those sensitivities, the researchers suggested.

Although prior epidemiologic and clinical studies have shown a close relationship between asthma and allergic rhinitis, the nature of the link between the two has remained unclear. The current study, however, provides new evidence that rhinitis is predictive of asthma development, the investigators said, along with support of hypotheses suggesting that rhinitis might be a cause of asthma.

In addition, the current findings suggest that bronchial hyperresponsiveness (BHR) is "an intermediate factor in the process leading from allergic rhinitis to asthma," the authors noted. Not only is allergic rhinitis shown in this and prior studies to be a risk factor for BHR in nonasthmatic adults, they said, but there is now substantial evidence that asymptomatic BHR frequently precedes—and can be considered a risk factor for—symptomatic asthma.

Because the association between asthma and allergic rhinitis in the current study decreased substantially after controlling for BHR, it is likely that part of the effect of allergic rhinitis on development of asthma is mediated through the development of BHR. "This observation is important, because BHR is thought to be a dynamic process, and can be decreased by anti-inflammatory therapy," the researchers said.

Interventional studies to assess the effects of rhinitis treatment on reducing the incidence of asthma—an effect that has been observed in clinical trials—are necessary to verify this effect, they concluded.

In an accompanying editorial, Dr. Erika von Mutius of University Children's Hospital in Munich wrote, "the idea that allergic rhinitis could cause asthma raises the possibility of preventing asthma by preventing atopic sensitization, which could in turn prevent allergic rhinitis."

The long-term preventive effect that immunotherapy might have is unknown, although it can improve nasal symptom scores, reduce airway responsiveness, and thus cut asthma burden in patients with allergic rhinitis (Lancet 2008;372:1012-4). But, "even if immunotreatments work, the fairly low population-attributable risk might diminish the overall effect of this therapeutic approach," she warned. ■

BRIEF SUMMARY - Consult full prescribing information before use.

TussiCaps®
(Hydrocodone Polistirex and
Chlorpheniramine Polistirex)
Extended-Release Capsules

Rx only

CONTRAINDICATIONS

TussiCaps® extended-release capsules are contraindicated in patients with a known allergy or sensitivity to hydrocodone or chlorpheniramine.

The use of TussiCaps® extended-release capsules are contraindicated in children less than 6 years of age due to the risk of fatal respiratory depression.

WARNINGS

Respiratory Depression – As with all narcotics, TussiCaps® extended-release capsules produce dose-related respiratory depression by directly acting on brain stem respiratory centers. Hydrocodone affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. Caution should be exercised when TussiCaps® extended-release capsules are used postoperatively and in patients with pulmonary disease, or whenever ventilatory function is depressed. If respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride and other supportive measures when indicated (see OVERDOSAGE).

Head Injury and Increased Intracranial Pressure – The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions, which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions – The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

Obstructive Bowel Disease – Chronic use of narcotics may result in obstructive bowel disease especially in patients with underlying intestinal motility disorder.

Pediatric Use – The use of TussiCaps® extended-release capsules are contraindicated in children less than 6 years of age (see CONTRAINDICATIONS).

In pediatric patients, as well as adults, the respiratory center is sensitive to the depressant action of narcotic cough suppressants in a dose-dependent manner. Caution should be exercised when administering TussiCaps® extended-release capsules to pediatric patients 6 years of age and older. Overdose or concomitant administration of TussiCaps® extended-release capsules with other respiratory depressants may increase the risk of respiratory depression in pediatric patients. Benefit to risk ratio should be carefully considered, especially in pediatric patients with respiratory embarrassment (e.g., croup) (see PRECAUTIONS).

PRECAUTIONS

General

Caution is advised when prescribing this drug to patients with narrow-angle glaucoma, asthma, or prostatic hypertrophy.

Special Risk Patients – As with any narcotic agent, TussiCaps® extended-release capsules should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy, or urethral stricture. The usual precautions should be observed and the possibility of respiratory depression should be kept in mind.

Information for Patients

As with all narcotics, TussiCaps® extended-release capsules may produce marked drowsiness and impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly. TussiCaps® extended-release capsules must not be diluted with fluids or mixed with other drugs as this may alter the resin-binding and change the absorption rate, possibly increasing the toxicity.

Keep out of the reach of children.

Cough Reflex – Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when TussiCaps® extended-release capsules are used postoperatively, and in patients with pulmonary disease.

Drug Interactions

Patients receiving narcotics, antihistamines, antipsychotics, anti-anxiety agents, or other CNS depressants

(including alcohol) concomitantly with TussiCaps® extended-release capsules may exhibit an additive CNS depression. When combined therapy is contemplated, the dose of one or both agents should be reduced.

The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone.

The concurrent use of other anticholinergics with hydrocodone may produce paralytic ileus.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenicity, mutagenicity and reproductive studies have not been conducted with TussiCaps® extended-release capsules.

Pregnancy

Teratogenic Effects. Pregnancy Category C – Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. TussiCaps® extended-release capsules should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects – Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.

Labor and Delivery

As with all narcotics, administration of TussiCaps® extended-release capsules to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers

It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from TussiCaps® extended-release capsules, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use

The use of TussiCaps® extended-release capsules are contraindicated in children less than 6 years of age (see CONTRAINDICATIONS and ADVERSE REACTIONS, Respiratory, Thoracic and Mediastinal Disorders).

TussiCaps® extended-release capsules should be used with caution in pediatric patients 6 years of age and older (see WARNINGS, Pediatric Use).

Geriatric Use

Clinical studies of hydrocodone polistirex and chlorpheniramine polistirex extended-release did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

This drug is known to be substantially excreted by the kidney, and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function.

ADVERSE REACTIONS

Gastrointestinal Disorders

Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of TussiCaps® extended-release capsules may produce constipation.

General Disorders and Administration Site Conditions

Death

Nervous System Disorders

Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, euphoria, dizziness, psychic dependence, mood changes.

Renal and Urinary Disorders

Ureteral spasm, spasm of vesical sphincters, and urinary retention have been reported with opiates.

Respiratory, Thoracic and Mediastinal Disorders

Dryness of the pharynx, occasional tightness of the chest, and respiratory depression (see CONTRAINDICATIONS). TussiCaps® extended-release capsules may produce

dose-related respiratory depression by acting directly on brain stem respiratory centers (see OVERDOSAGE). Use of TussiCaps® in children less than 6 years of age has been associated with fatal respiratory depression. Overdose with TussiCaps® extended-release capsules in children 6 years of age and older, in adolescents, and in adults has been associated with fatal respiratory depression.

Skin and Subcutaneous Tissue Disorders

Rash, pruritus.

DRUG ABUSE AND DEPENDENCE

TussiCaps® extended-release capsules are Schedule III narcotics. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, TussiCaps® extended-release capsules should be prescribed and administered with caution. However, psychic dependence is unlikely to develop when TussiCaps® extended-release capsules are used for a short time for the treatment of cough. Physical dependence, the condition in which continued administration of the drug is required to prevent the appearance of a withdrawal syndrome, assumes clinically significant proportions only after several weeks of continued oral narcotic use, although some mild degree of physical dependence may develop after a few days of narcotic therapy.

OVERDOSAGE

Signs and Symptoms – Serious overdosage with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme miosis progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. Although miosis is characteristic of narcotic overdose, mydriasis may occur in terminal narcosis or severe hypoxia. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur. The manifestations of chlorpheniramine overdosage may vary from central nervous system depression to stimulation.


Treatment – Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and the institution of assisted or controlled ventilation. The narcotic antagonist naloxone hydrochloride is a specific antidote for respiratory depression which may result from overdosage or unusual sensitivity to narcotics including hydrocodone. Therefore, an appropriate dose of naloxone hydrochloride should be administered, preferably by the intravenous route, simultaneously with efforts at respiratory resuscitation. Since the duration of action of hydrocodone in this formulation may exceed that of the antagonist, the patient should be kept under continued surveillance and repeated doses of the antagonist should be administered as needed to maintain adequate respiration. For further information, see full prescribing information for naloxone hydrochloride. An antagonist should not be administered in the absence of clinically significant respiratory depression. Oxygen, intravenous fluids, vasopressors and other supportive measures should be employed as indicated. Gastric emptying may be useful in removing unabsorbed drug.

A Schedule CIII Narcotic.

For Medical Information

Contact: Product Monitoring Department
Phone: 800-778-7898

Manufactured by:
Mallinckrodt Inc.
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