

Step-Down Therapy Feasible for Stabilized Asthma

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SAN DIEGO — Once-a-day step-down therapy can be an option for patients with mild, persistent asthma that has been stabilized by an inhaled corticosteroid, according to preliminary results from a 500-patient clinical trial presented at the international conference of the American Thoracic Society.

Dr. Stephen P. Peters said one puff a day

of a fluticasone (100 mcg) and salmeterol (50 mcg) combination was as effective as 100 mcg of low-dose fluticasone twice a day. Only 20% of patients on either therapy failed treatment in the 15-week study.

A third group of patients did not fare as well on a pill containing 5 mg or 10 mg of montelukast each day. About 30% of patients failed treatment. Investigators calculated the relative risk of treatment failure as 60% higher than with fluticasone alone or fluticasone/salmeterol. Even so,

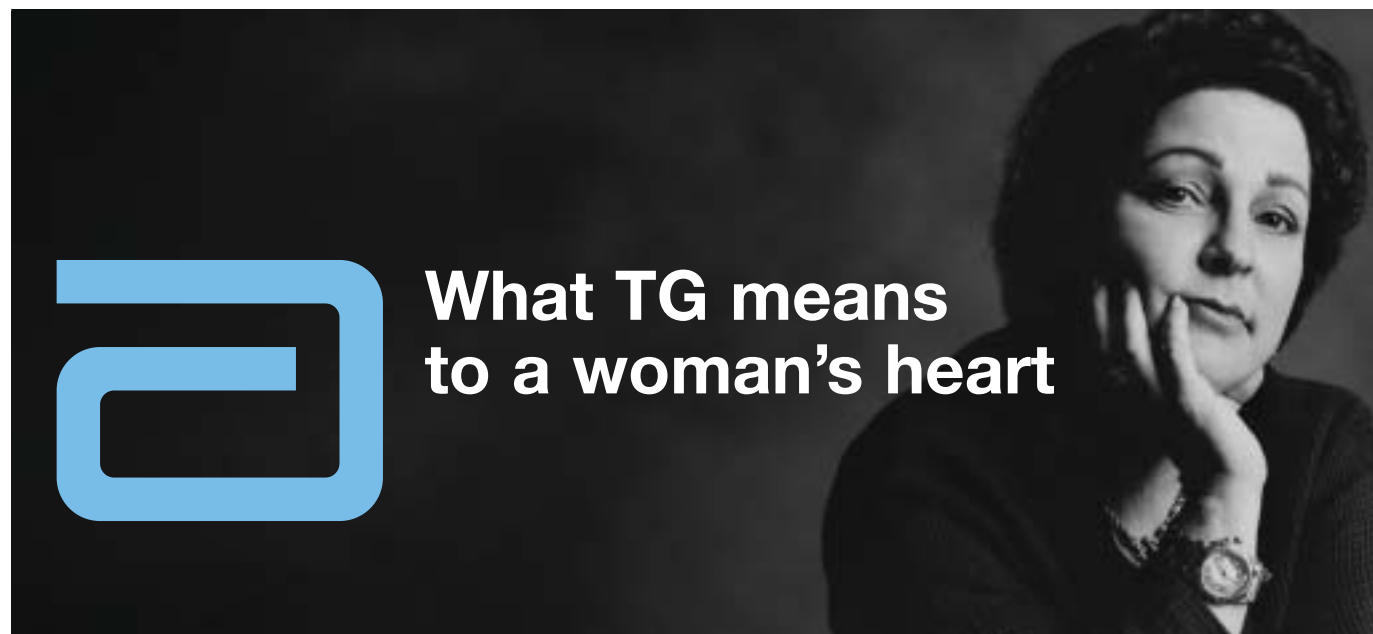
the patients on montelukast fared well enough that all three regimens are viable, said Dr. Peters, director of research in pulmonary and critical care medicine at Wake Forest University, Winston-Salem, N.C.

"Although twice-a-day inhaled corticosteroid remains the treatment of choice for persistent asthma, alternatives could be considered on a case-by-case basis," he said, citing the fluticasone/salmeterol combination. "There are still a lot of folks ... who also did well, even on montelukast."

The study, known as the Leukotriene Modifier or Corticosteroid or Corticosteroid-Salmeterol Trial, was sponsored by the American Lung Association's Asthma Clinical Research Centers. An unrestricted grant from GlaxoSmithKline provided financial support.

The trial randomized 168 patients to fluticasone, 162 patients to fluticasone/salmeterol, and 165 patients to montelukast after a phase-in period during which mild asthma was stabilized on an inhaled corticosteroid. Dr. Peters said all patients took a pill and used inhalers without knowing which one of their treatments had an active ingredient and which two were placebo.

The population was evenly divided between men and women and had an average age of 31 years. About 18% of patients were children, and more than a third were



What TG means to a woman's heart



Twice-a-day inhaled corticosteroid is the treatment of choice, but alternatives could be considered.

DR. PETERS

African American or Hispanic. As a group, they were longtime asthma patients with an average of 16 years since diagnosis. Dr. Peters characterized the participants as "the group we are used to seeing."

The trial's primary outcome was time to treatment failure, which the investigators defined in seven ways, including physician judgment. Patients who had treatment failures could have more than one reason for a treatment failure.

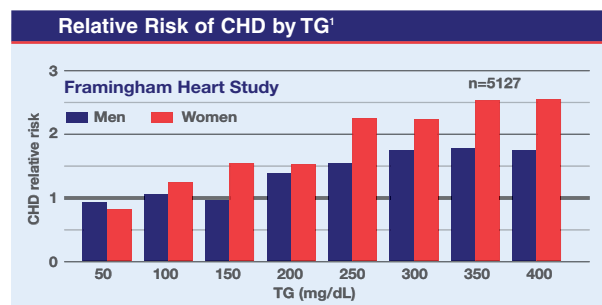
There were 50 treatment failures with montelukast, 34 with fluticasone, and 33 with fluticasone/salmeterol. The most common reason was a 20% or greater drop in forced expiratory volume in 1 second (FEV₁), which 48% of patients with treatment failures experienced: 26 patients on montelukast, 16 on the combination, and 14 on single-agent fluticasone.

Three components of asthma exacerbation accounted for a total of 48% of treatment failures: systemic steroids, inhaled corticosteroid use (not counting exercise medication), and urgent care. The proportion of patients with asthma exacerbation was similar: 13% with montelukast, 11% with fluticasone/salmeterol, and 10% with fluticasone alone. The only significant difference was in inhaler use when montelukast was compared with fluticasone/salmeterol (23% vs. 17%).

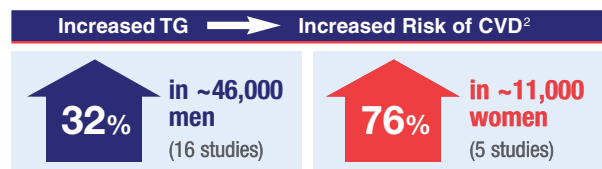
In other measures, Dr. Peters said montelukast was "slightly inferior" for nocturnal awakenings, prebronchodilator FEV₁, and responses on the Asthma Control Questionnaire. Fluticasone/salmeterol was "slightly superior" for morning peak expiratory flow. He reported no difference in the Asthma Symptom Utility Index, Adult Asthma Quality of Life, serious adverse events, or percentage of symptom-free days (79% vs. 86%). For all three groups, most days were symptom free and rescue inhaler use was infrequent. Adherence is an underlying issue, he said in an interview. ■

Elevated Triglycerides Make a Difference in Women's Risk of CHD

While great attention and clinical efforts have been directed toward LDL-C-lowering, the Framingham Heart Study 30-year follow-up clearly showed that elevated triglycerides (TG) are also associated with an increased relative risk of coronary heart disease (CHD) — especially in women.¹



In addition, meta-analyses demonstrated that every 1 mmol/L (89 mg/dL) increase in TG increased cardiovascular disease (CVD) risk by²:



CHD is the #1 Killer of Women

The effect of elevated TG in women is important to keep in mind in view of the fact that CHD is the single leading cause of death among American women, claiming nearly 500,000 lives each year.³ Menopausal women are particularly at risk, with CHD rates 2 to 3 times those of women the same age who are premenopausal.³

CHD Risks With Diabetes or Metabolic Syndrome* in Women: Role of TG and HDL-C

Of the estimated 16 million Americans with diabetes, more than half are women.⁴ In women, diabetes is a powerful risk factor for CHD, increasing CHD risk 3-fold to 7-fold compared to a 2-fold to 3-fold increase in men.⁵ It has also been shown that metabolic syndrome is associated with a 2-fold risk of CHD mortality in women.⁶ **It is important to note that the most common pattern of dyslipidemia in patients with type 2 diabetes is elevated TG levels and decreased HDL-C levels.⁷**

*At least 3 of the 5 criteria: abdominal obesity with waist circumference >102 cm in men and >88 cm in women; triglycerides ≥150 mg/dL; HDL-C <40 mg/dL in men and <50 mg/dL in women; blood pressure ≥130/85 mmHg; fasting glucose ≥110 mg/dL.⁸

More Aggressive Guidelines for TG and HDL-C

While LDL-C lowering is recognized as the primary lipid target to reduce CHD morbidity and mortality, it does not remove all risk.⁹ Recent data has shed more light on the role of increased TG and decreased HDL-C in CHD risk. It is critical that these lipid abnormalities be considered and managed, in addition to LDL-C. In fact, the current National Cholesterol Education Program (NCEP) guidelines recommend more aggressive TG and HDL-C target goals.⁸ The American Heart Association (AHA) and American Diabetes Association (ADA) recommend similar aggressive goals for TG (<150 mg/dL) and HDL-C (>50 mg/dL) in CVD prevention for women.^{10,11}

You Can Help Make a Difference

A majority of women are still not aware of the substantial CHD risks posed by abnormal lipid levels.¹² As a physician, you can help make a difference by raising your female patients' awareness of these issues, and by helping them achieve optimal lipid levels, as recommended by the NCEP, the AHA and the ADA.

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