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Ventolin Diskus and Insypril Turbuhaler: An In Vitro Comparison

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ABSTRACT

Dose delivery (total emitted dose, or TED) from dry powder inhalers (DPIs), pulmonary deposition, and the biological effects depend on drug formulation and device and patient characteristics. The aim of this study was to measure, in vitro, the relationship between parameters of inhalation profiles recorded from patients, the TED and fine particle mass (FPM) of Diskus and Turbuhaler inhalers. Inhalation profiles (IPs) of 25 patients, a representative sample of a wide range of 1500 IPs generated by 10 stable asthmatics, 3 mildly/moderate/severely COPD patients and 15 hospitalized patients with an exacerbation asthma or COPD, were selected for each device. These 25 IPs were input IPs for the Electronic Lung (a computer-driven inhalation simulator) to determine particle size distribution from Ventolin Diskus and Insypril Turbuhaler. The TED and FPM of Diskus and FPM of Turbuhaler were affected by the peak inspiratory flow (PIF) and not by slope of the pressure-time curve, inhaled volume and inhalation time. This flow-dependency was more marked at lower flows (PIF < 40 L/min). Both the TED and FPM of Diskus were significantly higher as compared to those of the Turbuhaler [mean (SD) TED_diskus (%label claim) 83.5 (13.9) vs. TED_turbuhaler (72.5 (11.1) (p = 0.004), FPM_diskus (%label claim) 36.8 (9.8) vs FPM_turbuhaler (28.7 (7.7) (p < 0.05)). The TED and FPM of Diskus and FPM of Turbuhaler were affected by PIF, the flow-dependency being greater at PIF values below 40 L/min. Lower PIFs occurred more often when using Turbuhaler than Diskus, since Turbuhaler have a higher resistivity, requires substantially higher pressure in order to generate the same flow as Diskus. TED, dose consistency and the FPM were higher for Diskus as compared to Turbuhaler. The flow dependency of TED and FPM was substantially influenced by inhalation profiles when not only profiles of the usual outpatient population were included but also the real outliers from exacerbated patients.

Key words: dry powder inhaler, diskus, turbuhaler, electronic lung, fine particle mass

INTRODUCTION

THE EFFICACY of inhaled drugs to the lungs includes three steps: dose delivery from the inhaler (total emitted dose, or TED) that results in a certain dose to patient, pulmonary deposition of the TED, and the biological effects of the dose.1 The TED and aerosolisation of drugs delivered by dry powder inhalers (DPIs) depend on its formulation, device characteristics (e.g., resistance to
airflow, or resistivity), airway characteristics and
patient’s inhalation technique. The inspiratory
effort generates a negative pressure drop in the
mouth. The mouth-pressure versus time curve
was defined as the inhalation profile (IP). When
the resistivity is known, the pressure profile can
be converted into a flow profile. Peak inspira-
tory flow (PIF), slope of pressure versus time,
inhaled volume (Vi), and inhalation time (Ti)
are variables of the inhalation profile which may
influence the TED.

Conventionally, the in vitro methods testing the
TED and the fine particle mass (FPM) (the
amount of drugs in the respirable range, 0.5–5
μm) are based on impaction on the Cascade Im-
pactor tested at constant flows. These measure-
ments played an important role in the develop-
ment and optimisation of inhalation devices.
The relationship between in vitro and in vivo
is still unclear. Most of the particle-size systems op-
erate at constant and fixed flows (30, 60 and 90
L/min) typically from a pump, which do not
mimic the actual patients’ IP.

In the present study, two multidose dry pow-
der inhalers (DPI) were compared in vitro; the In-
spyril Turbuhaler® (AstraZeneca, Sweden) con-
tains 100 doses of 100/200 μg salbutamol (spherical
pellets) stored in a reservoir dosing unit, and the
Ventolin Diskus® (or Accuhaler®, GlaxoSmith-
Kline, UK), which contains 60 individually sealed
metered doses of 200/400 μg salbutamol plus a lac-
tose carrier.

A selection of typical “real life” inhalation pro-
files of patients with asthma and COPD with a wide
range of bronchial obstruction was im-
ported in a computer-driven inhalation simula-
tor, the Electronic Lung (GlaxoSmithKline Re-
search and Development Ware, UK). The purpose of this study was to measure the effects
of the inhalation profile variables on the TED and FPM. Furthermore, differences of TED and FPM
between the two devices were also assessed.

MATERIALS AND METHODS

Study design

In two previous studies, inhalation profiles were recorded with the Inhalation Profile
Recorder11,12 (GSK R&D Dept., Ware UK). In 10 stable asthma patients and three groups (mild,
moderate and severe) of 16 COPD patients, 18 in-
halation profiles were recorded for each device
during six sessions over 10 weeks. Also, 15 hos-
pitalized patients participated in a randomized
study of inhalation profiles through placebo de-
vice. For each device, triplicate inhalation prof-
files were recorded during day 1–9 of admission
and in stable phase.

Twenty-five inhalation profiles with a wide
range of characteristics were selected for Diskus
and twenty-five inhalation profiles were selected
for Turbuhaler from the total of 3000 profiles
collected in these studies and were the input for the
Electronic Lung13,14 (GlaxoSmithKline R&D
Dept., Ware UK), which enabled us to measure
TED and the FPM.

Materials used

The study included the use of Ventolin Diskus
inhaler, 200 μg/dose (GlaxoSmithKline, UK) and
the Inspyril Turbuhaler inhaler, 100 μg/dose (AstraZeneca, Sweden).

Inhalation profile

The inhalation profiles (pressure vs time) were
recorded by a pressure transducer: the Inhalation
Profile Recorder11 (GSK R&D Dept., Ware UK).
The transducer measured pressures in the mouth-
piece during the inhalation through a placebo
Diskus and Turbuhaler. The variables of the in-
halation profile recorder are pressure slope
(Slope) (kPa/sec), peak pressure drop (PPD)
(kPa), time to peak pressure drop: the time be-
tween the onset of the inhalation and the moment
of reaching the PPD (Tp) (sec) (the start of the
measuring time is the moment that the pressure
passes the 0.2-kPa threshold), peak inspiratory
flow (PIF) (L/min), inhaled volume (Vi) (L) and
inhalation time (Ti) (sec). The relationship be-
tween PIF and PPD was calculated

\[
\text{PIF} = \frac{\text{PPD}}{R}
\]

where R is the resistivity of the device

\[
R_{\text{diskus}} = 0.02133 \text{ (kPa) }^{0.5} \text{ (L/min)}^{-1}
\]

and

\[
R_{\text{turbuhaler}} = 0.03223 \text{ (kPa) }^{0.5} \text{ (L/min)}^{-1}
\]

Electronic lung

The Electronic Lung is a computer-driven in-
halation simulator14,16 (Fig. 1). In vitro IPS of pa-
tients were replicated. Next the mass and parti-
cle size distributions of drug delivered from a
Ventolin Diskus and Turbuhaler were deter-
mained. The powder was drawn from the device
into the metal sampling chamber by a computer-
driven piston, programmed by the IP. Then, the powder was extracted from the chamber by a second pump that was switched on after completion of the inhalation through an Anderson Cascade Impactor (Graseby Anderson Ltd, Orpington, UK) operating at 60 L/min. This was repeated 10 times to obtain a sufficient amount of drug for analyzing. The total emitted dose (TED) was the sum of the amounts of drug in the throat inlet, sampling chamber, and Cascade Impactor. The cumulative dose of the sampling chamber, throat, and the preseparator of the Cascade Impactor was labeled as coarse particle mass (CPM). The accumulated amount of drug on stages 1–5 of the Cascade Impactor represented the fine particle mass (FPM, 0.76–4.0 μm), whereas the particles on stages 6 and 7 plus the filter were termed very fine particle mass (VFPM, <0.76 μm).

The throat, sampling chamber, preseparator, and all stages were washed out with a suitable solvent. The TED, CPM, FPM, and VFPM were determined by high-performance liquid chromatography (HPLC).

Statistical analysis

SPSS for windows version 9.0 was used for calculating means of the inhalation parameters. Data were expressed as mean ± SD. A p value of <0.05 was considered significant.

To select the inhalation profiles which had to be a representation of the range of the different profiles generated in the study, it was assumed that the profiles were adequately described by PIF, slope, Vi, and Ti. These parameters were plotted in a four dimensional hypercube design. Four center inhalation profiles were selected to give a representation of the middle range. Points were taken as extreme if they were below the 25th percentile or above the 75th percentile. As far as possible the 16 combinations of the four factors: PIF; slope; Vi and Ti (each at two levels) were used to select the inhalation profiles that correspond to these design points. For each device five extra plots in the lowest peak flow range were selected. These selection of inhalation profiles gave the widest span of the data (not only of the usual outpatient population, but also outliers from the extremes of disease severity during exacerbation).

Regression models were fitted (using JMP statistical software) for TED, FPM as percentage of label claim and FPM as percentage of TED with the natural logarithm of PIF as an explanatory variable. Device differences were also investigated, as was the effect of TED on FPM.

RESULTS

A total of 1500 inhalation profiles through each device was recorded from asthmatics and
COPD patients. For both Diskus and Turbuhaler, inhalation profiles of 25 patients were run with the Electronic Lung. The demographics of the patients from whom the selected inhalation profiles were taken, are shown in Table 1.

**Inhalation profile variables**

The mean inhalation profile variables are shown in Table 2. The PIF values of the Diskus were significantly higher as compared to Turbuhaler (mean [SD]: 100.1 [30.8] vs. 69.2 [19.3] L/min \(p < 0.001\)). The inhalation time of Turbuhaler was significantly longer as compared to Diskus (mean [SD] 3.3 [1.3] vs. 2.5 [1.1] sec \(p = 0.03\)).

**Effect of inhalation profile variables on total emitted dose**

Table 3 shows the Electronic Lung results (TED and FPM) for both devices. Initially, the effect of PIF was assessed, since this is believed to be the most likely variable to influence the Electronic Lung results. Figure 2 shows the relationship between TED and PIF. No significant correlation between PIF and TED was found for the Turbuhaler. Overall, the TED for Diskus was significantly higher than for Turbuhaler, but over a small increase in TED for Diskus, there appeared to be a slight flow dependency.

**Fine particle mass as percentage of label claim**

Ln(PIF) and TED both had statistically significant effects on FPM (percentage label claim). There was no additional contribution of the device type once these effects were accounted for.

\[
\text{FPM} = -49.4 + 0.32 \ln(\text{PIF}) + 0.41 \text{TED} + 0.88 \ln(\text{TED})
\]

\(p < 0.0001\)

\(r^2 = 0.88\)

### Table 1. Patient Characteristics

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Diskus</th>
<th>Turbuhaler</th>
</tr>
</thead>
<tbody>
<tr>
<td>(\text{FEV}_1%\text{pr}) (%)</td>
<td>63 (22.1)</td>
<td>66 (26.7)</td>
</tr>
<tr>
<td>(\text{FEV}_1) (L)</td>
<td>1.7 (0.7)</td>
<td>1.7 (0.8)</td>
</tr>
<tr>
<td>(\text{FEV}_1/\text{VC}) (%)</td>
<td>49 (12.9)</td>
<td>50 (16.6)</td>
</tr>
<tr>
<td>Reversibility (%)</td>
<td>8 (6.6)</td>
<td>6 (4.0)</td>
</tr>
<tr>
<td>Device</td>
<td>DPI</td>
<td>pMDI</td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>9</td>
</tr>
<tr>
<td>Smoking: non/ex/current</td>
<td>7/13/5</td>
<td>3/7/5</td>
</tr>
<tr>
<td></td>
<td>3/7/5</td>
<td>3/7/5</td>
</tr>
</tbody>
</table>

\(\text{FEV}_1\%\text{pr}\), forced expiratory volume in 1 sec as percentage of predicted; \(\text{FEV}_1\), forced expiratory volume in 1 sec; \(\text{FEV}_1/\text{VC}\), \(\text{FEV}_1/vital\ capacity; \text{reversibility}, \text{bronchodilator response of } \text{FEV}_1\) (%) related to the predicted value; device, device used by the patients in daily life.
The effect of omitting the lowest PIF from the analysis

Recalculations of the fit without the lowest flows (PIF_diskus 23 L/min and PIF_turbuhaler 22 L/min) were performed.

\[
\text{TED}_{\text{diskus}} \left(\% \text{ label claim}\right) = 2.9 (1.1) [1.0-5.3] \\
\text{TED}_{\text{turbuhaler}} \left(\% \text{ label claim}\right) = 2.8 (1.1) \left[1.0-6.1\right]
\]

The \( r^2 \)-squared values for each of the two regression models are not significantly different, and there is no evidence that the model parameters change when the low flow data are omitted.

The residuals from these models have been plotted against the other inhalation profile variables (slope, Vi, and Ti). There was no indication for any other significant relationships.

Differences between the two devices

The Total Emitted Dose was significantly higher and marginally more variable overall for Diskus than for Turbuhaler (83.5 ± 13.9% vs. 72.5 ±11.1% label claim, \( p = 0.004 \)). There did not appear to be an effect due to device type at comparable inspiratory flows. The Turbuhaler having a higher resistivity, required substantially higher pressure, in order to generate the same flow at Diskus (Figs. 2 and 3).

DISCUSSION

The results of this study showed that the TED of Diskus was affected by the PIF, and no significant correlation between PIF and TED_turbuhaler was found. The FPM of Turbuhaler and Diskus were dependent of PIF and TED. These flow dependencies were more marked at the lower peak inspiratory flows (PIF < 40 L/min). Both the TED and FPM of Diskus were significantly higher as compared to Turbuhaler.

The aim of this study was to determine in vitro the drug delivery characteristics in respect of the delivered dose and particle size distribution of Diskus and Turbuhaler in asthma and COPD patients using real-life patient inhalation profiles. Inhalation profiles of these patients with a wide range of bronchial obstruction and inspiratory muscle function were replayed through the Electronic Lung: a computer-driven inhalation ma-

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Diskus (Mean (SD))</th>
<th>Turbuhaler (Mean (SD))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total emitted dose (% label claim)</td>
<td>83.5 (13.9)*</td>
<td>72.5 (11.1)</td>
</tr>
<tr>
<td>Total emitted dose (µg)</td>
<td>167.1 (27.8)*</td>
<td>72.5 (11.1)</td>
</tr>
<tr>
<td>Fine particle mass (% TED)</td>
<td>36.8 (9.8)*</td>
<td>28.7 (7.7)</td>
</tr>
<tr>
<td>Fine particle mass (µg)</td>
<td>73.7 (19.5)*</td>
<td>28.7 (7.7)</td>
</tr>
</tbody>
</table>

Mean inhalation profile variable: PIF, peak inspiratory flow; Vi, inhaled volume; Ti, inhalation time. *\( p < 0.05 \) differences between Diskus and Turbuhaler.

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### TABLE 2. Inhalation Profile Variables

<table>
<thead>
<tr>
<th>Mean (SD) [range]</th>
<th>Diskus</th>
<th>Turbuhaler</th>
</tr>
</thead>
<tbody>
<tr>
<td>PIF (L/min)</td>
<td>100.1 (30.8) [23.3-140.1]*</td>
<td>69.2 (19.3) [22.1-99.8]</td>
</tr>
<tr>
<td>Slope (kPa/sec)</td>
<td>13.2 (8.0) [1.0-38.2]</td>
<td>13.7 (9.0) [1.0-32.8]</td>
</tr>
<tr>
<td>Vi (L)</td>
<td>2.9 (1.1) [1.0-5.3]</td>
<td>2.8 (1.4) [1.0-6.1]</td>
</tr>
<tr>
<td>Ti (sec)</td>
<td>2.5 (1.1) [1.0-5.0]</td>
<td>3.3 (1.3) [1.1-5.8]*</td>
</tr>
</tbody>
</table>

*Mean inhalation profile variable: PIF, peak inspiratory flow; Vi, inhaled volume; Ti, inhalation time. *\( p < 0.05 \) differences between Diskus and Turbuhaler.

### TABLE 3. Electronic Lung Results

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Ventolin Diskus</th>
<th>Insignit Turbuhaler</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total emitted dose (% label claim)</td>
<td>83.5 (13.9)*</td>
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</tr>
</tbody>
</table>

Total emitted dose as percentage of label claim; fine particle Mass as percentage of label claim and as percentage of the total emitted dose. *\( p < 0.05 \) differences between Diskus and Turbuhaler.
noeuvre simulator. Conventional cascade impacters operate at constant flows, which is an unrealistic deviation from the actual flow patterns with respect to the drug release from the device. The airflow through a device during a patient’s inhalation not only varies with time, but also between inhalations and patients. The Electronic Lung realistically simulates drug delivery, with real flow patterns.

The selected inhalation profiles for this in vitro comparison of Diskus and Turbuhaler showed significant lower PIF values and higher inhalation times for Turbuhaler. This was due to the different resistivities (resistance to airflow) of both devices. PIF decreases with increasing resistivity, which subsequently increases the total inhalation time.

An appropriate and clinically efficient DPI should deliver a reliable, consistent dose and a large FPM, relatively independent of flow. The latter should possibly be generated with relatively low inspiratory pressures. In general, the TED for Inspyril Turbuhaler appeared to be significantly lower than that for Ventolin Diskus. This may be due to the fact that the PIF measurements were lower for Turbuhaler.

The present study showed that the TED\_diskus is affected by PIF and is mainly due to one very low result. Three relatively low TED\_turbuhaler results did not fit well with a linear regression. There was also an indication that the dependency of TED on PIF of both devices was more marked at lower flows.

The relatively high variability of TED for Ventolin Diskus appeared to be a result of one low result. This suggests that the variation in drug particle release may decrease with increasing effort. After fitting separate regression models for each device, the residual variability for Ventolin Diskus was less than that for Inspyril Turbuhaler. This means that the Diskus provided a more consistent dose delivery.

The flow-dependent drug output (TED), consistency of the dose, and number of particles in the respirable range (FPM) may theoretically lead to a decreased clinical efficacy in patients who are not able to generate an adequate flow through Diskus or Turbuhaler.

Both devices were extensively studied, both in vitro and in vivo. Our data confirmed the results of two other studies, which found that a higher FPM of Fluticasone Diskus was delivered at 60 L/min as compared to 30 L/min. Also, other in vitro device evaluations showed that the TED and FPM of the Turbuhaler increase at higher PIF. However, in contrast to our results, a
consistent dose delivery and FPM, relatively independent of flow was described by several studies for Diskus. Since dose emission properties are specific for each drug-device product and the results of this study are only applicable for Ventolin Diskus and Inspiryl Turbuhaler, the conclusions may not be extrapolated for the different combinations. Another important reason for variation may be attributed to the unrealistic test conditions in those studies, that only used a fixed flow Cascade Impactor. Nevertheless, this was not the first study using the Electronic Lung methodology. Several studies used the Electronic lung methodology rather than a fixed flow rate cascade impactor, which all demonstrate that dose delivery from the Diskus is independent of flow. The reason that our data seem to contradict these studies could be that the data chosen for our evaluation was in the range of 21/25 the extremes of the 1500 inhalation profiles collected for each device. Only 4/25 were selected from the middle range. This resulted in a population of inhalation profiles which included not only profiles of the usual outpatient population but also the real outliers from patients at the extremes of disease severity. These profiles were also acquired from severely exacerbated patients to whom a Diskus or Turbuhaler would normally not have been prescribed. So, the low profiles for Diskus and Turbuhaler were lower than collected in other studies. Recalculations of the fit without the lowest flows (PIF_diskus 23 L/min and PIF_turbuhaler 22 L/min) were performed and there was evidence that these outliers influenced the overall results of TED. For TED turbuhaler the slope was actually negative when the low flow data were removed. This was presumably influenced by the lowest TED result belonging to the highest PIF. The regression models for FPM (% label claim) with and without the low flow data were also calculated, but there was no evidence that the model parameters change when the low flow data were omitted.

This study demonstrated that in practice, different devices are not operating at corresponding flows by patients. Patients are only able to generate a certain (maximal) inspiratory effort (pressure) irrespective of which inhaler they inhale through. The inherent resistivity of the given device will determine the flow achieved through the device (Figs. 2 and 3). Comparison of the performance of inhalation devices with different resistivities at the same PIF must be considered carefully, since a particular flow may relate to an
VENTOLIN DISKUS AND INSPYRIL TURBUHALER

entirely different inspiratory effort in each device. Conventional in vitro measurements were usually performed with constant fixed flows of 30, 60 and 90 L/min. Nevertheless, the majority of patients inhaled with higher PIFs through the Diskus. So, the in vitro results in the PIF range 30–90 L/min are of high clinical relevance for Turbuhaler, but less for Diskus. Since the PIF is in general achieved after the release of the powder, the slope of the pressure profile (in kPa/sec) was also described as an important variable. Surprisingly, in the present study PIF seemed to influence the Electronic Lung results. There was no indication of a significant relationship with the other inhalation profile variables. However, it was shown for Diskus and Turbuhaler that peak inspiratory flow and slope correlate well in a wide range of patient groups.

In conclusion, the TED and FPM of Diskus and FPM of Turbuhaler for the salbutamol product were affected by PIF, the flow-dependency being greater for Diskus. Dose to patient (TED), dose consistency, and the mass of particles in the respirable range were higher for Diskus as compared to Turbuhaler. In vitro studies with a constant flow or with real-life flow profiles yield different results.

The flow dependency of TED and FPM of Diskus do not agree with other data published. This is likely to be due to the use of IPs, which include not only the usual clinical population but also the real outliers.

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