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Predictive value and utility of oral steroid testing for treatment of COPD in primary care: the COOPT Study

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Background: The oral prednisolone test is widely used to distinguish chronic obstructive pulmonary disease (COPD) patients who might benefit from inhaled steroid treatment. Previous studies used selected patient groups that did not represent the large COPD population in primary care.

Methods: The study included smokers and ex-smokers with chronic bronchitis or COPD from primary care, who underwent prednisolone testing (30 mg for 14 days) before randomization in a three-year follow-up randomized controlled trial (COOPT Study). Spirometry was performed before and after the test. Responders and nonresponders were classified according to international criteria. Effectiveness of inhaled fluticasone relative to placebo was compared in terms of health status (Chronic Respiratory Disease Questionnaire), exacerbations, and postbronchodilator forced expiratory volume in one second (FEV1), using repeated measurement analysis.

Results: Two hundred eighty-six patients recruited from 44 primary care practices were randomized. Nine percent to 16% of the COPD population was classified as responder, depending on the international guideline criteria used. On average, responders did not reach the minimum clinically important difference in health status (0.29 points/year, \( P = 0.05 \)), although a borderline significant effect of inhaled fluticasone was noted. Possible clinically relevant reductions in exacerbation rate (rate ratio 0.67) and FEV1 decline (39 mL/year) occurred in responders, but did not reach statistical significance.

Conclusions: Oral steroid testing identifies a limited proportion of COPD patients, but does not reveal any clinically relevant benefit from inhaled steroid treatment on health status. No significant effects on exacerbation rate and lung function decline occurred.

Keywords: COPD, primary care, oral steroid testing, prednisolone test
to oral steroids, thus foreshadowing the presumable efficacy of inhaled corticosteroid therapy. It is disputed what proportion of COPD patients suffer from persistent obstruction with a reversible component. Estimates differ from 10% to 30% depending on clinical setting. It is estimated that 20%–30% of patients with COPD may experience a significant improvement in FEV₁ from short-term corticosteroid use.

In case of persistent obstruction with a significant reversible component, a diagnostic prednisolone test can be performed, although the validity of this test is questioned and different cut-off points for ‘response’ are advised according to several international guidelines. Small, short-term studies in selected patient groups have described different regimes of prednisolone testing, and as a result the more or less accepted current form (14 days of 30 mg prednisolone) has been part of the diagnostic work-up of COPD-patients. However, the prednisolone test was never validated prospectively in a primary care population. In severe disease without reversibility it has recently been shown not to be useful by American Thoracic Society (ATS) criteria. As a consequence, the utility and predictive value of responders within the COPD population is vigorously debated.

The diagnostic prednisolone test is generally defined as a positive response. By contrast, the ERS criteria for a positive response, while the British Thoracic Society (BTS) stated an increase of ≥15% of baseline FEV₁ as a positive response. By contrast, the ERS used to recommend a ≥10% increase of FEV₁ predicted in their guidelines, but this recommendation has been left out in the 2004 ERS/ATS Guidelines. Specific criteria for positive response have consequently also been deleted from the British NICE Guidelines and the executive summary of the GOLD Guidelines.

Differences in longitudinal scores on health status, exacerbation frequency, and postbronchodilator FEV₁ were tested on an intention to treat basis, by using statistical techniques for repeated measurements. The placebo group has been taken as representing the natural course, relative to the intervention groups. For statistical testing of differences in exacerbation frequency between placebo and intervention groups during the study period we used a correlated time-event model (GENMOD-procedure in SAS; Poisson distribution, compound symmetry correlation structure). To analyze the effects on health status, a longitudinal analysis...
was performed on the CRQ-total score, while decline analyses for repeated FEV₁ measurements were used for statistical testing of differences in annual lung function. The regression model for these outcomes accounted for correlation between repeated measurements²⁷ (PROC MIXED in SAS, compound symmetry correlation structure).

Results
The study population is described in Table 1. The number of responders differs from 25 (9%, ERS) to 44 (16%, ATS) depending on guideline used. Responders show a significantly higher proportion of females, almost equalling men, in comparison with nonresponders across all guidelines. Age, smoking behavior, pack-years, degree of obstruction, and reversibility to bronchodilator do not differ significantly.

The long-term effectiveness of fluticasone propionate relative to placebo in responders versus nonresponders is shown according to different guideline criteria. Outcome variables are exacerbation rate, health status, and postbronchodilator FEV₁. On average, clinically relevant differences in health status were not reached. Responders according to ERS experienced a borderline significant effect of inhaled fluticasone on health status (0.29 points/year, \(P = 0.05\)), and to a lesser extent in BTS responders (0.26 points/year, \(P = 0.06\)). ATS-responders did not experience any significant benefit from long-term fluticasone use. Possible clinically relevant reductions in exacerbation rate (rate ratio 0.67) and FEV₁ decline (39 mL/year) occurred in BTS responders, but did not reach statistical significance. These effects were similar (rate ratio 0.68, FEV₁ decline 30 mL/year) in ERS-responders, while much smaller in ATS responders (rate ratio 0.78, FEV₁ decline 8 mL/year).

Discussion
To our knowledge, this study for the first time prospectively relates the responses to long-term inhaled corticosteroid therapy to different cut-off points for prednisolone testing in primary care. Between 9% to 16% of the COPD population was classified as a responder depending on criteria used. On average, clinically relevant differences in health status were not reached. Responders according to the former ERS guideline (FEV₁ increase of ≥10% predicted) experienced a borderline significant effect of inhaled fluticasone on health status (0.29 points/year, \(P = 0.05\)) during three years of treatment. A similar, but not significant effect on health status (0.26 points/year, \(P = 0.06\)) was seen using the former BTS criteria, while ATS responders showed less effect (0.20 points/year). Possible clinically relevant reductions in exacerbation rate (rate ratio 0.67) and FEV₁ decline (39 mL/year) occurred in responders according to BTS, but did not reach statistical significance. Similar results were seen in the ERS group (rate ratio 0.68 and +30 mL, respectively) but were less similar when the ATS criteria was applied (rate ratio 0.77 and +8 mL, respectively).

Interestingly, the only other long-term prospective study²¹ that assessed prednisolone testing on these outcomes, but not in a primary care population, concluded on the basis of using ATS criteria that there was ‘no relationship between the

<table>
<thead>
<tr>
<th>Table 1 Population characteristics of responders versus nonresponders according to former international guidelines¹³–¹⁵</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total group</strong></td>
</tr>
<tr>
<td>Number</td>
</tr>
<tr>
<td>(% of total)</td>
</tr>
<tr>
<td>Age (range)</td>
</tr>
<tr>
<td>Gender (f/m)</td>
</tr>
<tr>
<td>(% female)</td>
</tr>
<tr>
<td>Smoking (curr/form)</td>
</tr>
<tr>
<td>(% current)</td>
</tr>
<tr>
<td>Pack years (SD)</td>
</tr>
<tr>
<td>FEV₁ postBD (%Spred)</td>
</tr>
<tr>
<td>FVC postBD (%Spred)</td>
</tr>
<tr>
<td>FEV₁/FVC (SD)</td>
</tr>
<tr>
<td>BD-Reversibility (%)</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
</tr>
</tbody>
</table>

Notes: *Statistical difference between responders and nonresponders, \(P < 0.05\).

Abbreviations: ATS, American Thoracic Society; BD, bronchodilators; BMI, body mass index; BTS, British Thoracic Society; ERS, European Respiratory Society; FEV₁, forced expiratory volume in one second; FVC, forced vital capacity; SD, standard deviation.
short term response to prednisolone and the rate of decline in FEV$_1$ or health status’. In fact, our results are in line with that widely cited study, since we only found any possibly meaningful results using the ERS and BTS criteria. In addition, the Isolde researchers looked at the so-called Callahan criteria (FEV$_1$ increase of 20% of baseline), which were derived from a meta-analysis looking at oral corticosteroid therapy, not prednisolone testing. In fact, this cut-off indeed also showed a significant effect, but this was deemed by the Isolde researchers to be the result of confounding. Thus, the criteria used appears to matter and we cannot recommend the use of the former ATS criteria when performing prednisolone trials, based on our results and on those of the Isolde researchers.

In our study, the proportion of primary care COPD patients meaningfully labeled as responder ranges from 9% (ERS) to 12% (BTS), which is considerably lower than expected. We therefore fear that our study was underpowered, since estimates in literature ranged from 20%–30% responders. However, it is also possible that we underestimated the number of potential responders in the population, since for ethical reasons our study design provided a wash-out period to exclude all patients that experienced more than two exacerbations when inhaled steroids were taken in the three months preceding entry to the study.$^{29}$ In our population, this means that steroid-dependent patients were not allowed to enter the study.

Contrary to the Isolde researchers, we found a significant gender difference in prednisolone responsiveness across all criteria groups. Women appear particularly prone to COPD when exposed to similar amounts of tobacco$^{29}$ and interestingly, the proportion of female COPD patients responding to prednisolone was consistently higher than among nonresponders at baseline. No other significant differences were seen between responders and nonresponders in terms of age, lung function, current smoking, or pack-years of smoking. This apparent gender difference in prednisolone response therefore deserves further study, since earlier studies probably did not include sufficient numbers of females with COPD, whose prevalence has been seen to rise only in recent years.

In this study, a clear history of asthma, allergic rhinitis or atopic eczema was an exclusion criterion, while reversibility to bronchodilators was not. However, we found no relationship between prednisolone response and bronchodilator reversibility, which was very similar across all criteria groups (Table 1). We consider it highly relevant to clinical practice that reversibility to bronchodilators apparently does not correspond to prednisolone responsibility, since these terms are sometimes interchangeably used as parameters of the same phenomenon. These study data indeed suggest that the response to oral steroids may describe a different underlying inflammatory process than the response to bronchodilation, which is of a fundamentally different origin.

Our results suggest a borderline significant effect on health status in ERS responders, but is it clinically meaningful? The minimum clinical difference on the CRQ is 0.5 points, which is clearly higher than the 0.29 points reached on average in our study, which renders this result marginal. However, the rate ratio for exacerbations (32% less than placebo) and even the FEV$_1$ decline (30 mL/year less than placebo) point in the same direction in both the ERS

### Table 2 Long-term effectiveness of fluticasone propionate versus placebo in responders and nonresponders on exacerbations, health status, and lung function according to different international guidelines

<table>
<thead>
<tr>
<th>Variables</th>
<th>Total group</th>
<th>ERS Responders</th>
<th>ERS Nonresponders</th>
<th>ATS Responders</th>
<th>ATS Nonresponders</th>
<th>BTS Responders</th>
<th>BTS Nonresponders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exacerbations</td>
<td>FLU</td>
<td>0.98</td>
<td>0.71</td>
<td>0.93</td>
<td>0.56</td>
<td>0.96</td>
<td>0.63</td>
</tr>
<tr>
<td>Rate ratio</td>
<td>Pla</td>
<td>0.73</td>
<td>1.04</td>
<td>0.70</td>
<td>0.73</td>
<td>0.73</td>
<td>0.94</td>
</tr>
<tr>
<td>Health status</td>
<td>FLU</td>
<td>+0.15</td>
<td>+0.30</td>
<td>+0.14</td>
<td>+0.29</td>
<td>+0.14</td>
<td>+0.29</td>
</tr>
<tr>
<td>Rate ratio</td>
<td>Pla</td>
<td>+0.13</td>
<td>+0.01</td>
<td>+0.13</td>
<td>+0.09</td>
<td>+0.13</td>
<td>+0.03</td>
</tr>
<tr>
<td>Annual difference</td>
<td>FLU</td>
<td>+0.02</td>
<td>+0.29*</td>
<td>+0.01</td>
<td>+0.20</td>
<td>+0.01</td>
<td>+0.26</td>
</tr>
<tr>
<td>FEV$_1$-change</td>
<td>Pla</td>
<td>−69</td>
<td>−97</td>
<td>−56</td>
<td>−69</td>
<td>−58</td>
<td>−99</td>
</tr>
<tr>
<td>(mL)</td>
<td>Pla</td>
<td>+1</td>
<td>+30</td>
<td>+2</td>
<td>+8</td>
<td>−1</td>
<td>+39</td>
</tr>
</tbody>
</table>

Notes: *Statistical difference between responders and nonresponders, P < 0.05.
Abbreviations: ATS, American Thoracic Society; BTS, British Thoracic Society; ERS, European Respiratory Society; FEV$_1$, forced expiratory volume in one second; FLU, Pla, platelets.
and BTS groups (33% less exacerbations and 39 mL/year less FEV₁ decline, respectively), which may indicate possible clinical relevance. The systematical difference in effects on all three outcomes compared to the nonresponders (and indeed the total group of COPD patients) suggests that this rather small group of responders to prednisolone could be a limited subgroup in primary care, which would need different medical treatment. Since the number of responders (using the ERS or BTS criteria) now can be expected to be around 10% in a primary care population like ours, we think these results would probably need replication in a larger primary care study. This small but possibly relevant proportion is identical to the 10% that was found in the earlier meta-analysis on the benefits of oral corticosteroid therapy for COPD patients.12 As has been stated before,30 it is important to keep an open mind about the possibility that there may be responder and nonresponder subgroups and to continue to seek ways to identify and characterize them, especially in primary care where heterogeneity is common.20

Conclusions
Oral steroid testing distinguishes a limited proportion of COPD patients, but does not reveal clinically relevant benefit from inhaled steroid treatment on health status. No significant effects on exacerbation rate and lung function decline occurred.

Acknowledgments
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References


