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Megatrials for Bronchodilators in Chronic Obstructive Pulmonary Disease (COPD) Treatment: Time to Reflect

Wouter D. van Dijk, MD, Lisette van den Bemt, PhD, and Chris van Weel, MD, PhD

Introduction: Chronic obstructive pulmonary disease (COPD) is an important cause of morbidity and mortality worldwide. Although (long-acting) bronchodilators are used to relieve symptoms, the impact of bronchodilators on COPD mortality remains an unresolved issue. Our aim was to explore the results and the interpretations of the results of studies of bronchodilator treatment from high-impact COPD trials.

Methods: We searched PubMed and Embase for primary publications of randomized controlled trials with more than 1000 participants with COPD and that studied the effectiveness of long-acting bronchodilator treatment. We assessed population characteristics, primary outcomes, focus of outcomes, and possible bias from concomitant pulmonary medication.

Results: We retrieved 5 primary publications of large trials. Participants tended to be patients with rather severe COPD who were cared for at a hospital. Only half of the primary outcomes were statistically significant. Reports tended to focus on statically significant outcomes and not necessarily on primary outcomes or outcomes of the whole study population. The relevance of study outcomes was rarely discussed.

Discussion: The rather small effects of bronchodilators in a COPD population that is not representative for daily care, together with the tendency of relying on statistical rather than clinical significance, hampers translation to the large number of patients with COPD in the community. (J Am Board Fam Med 2013;26:221–224.)

Keywords: Bronchodilators, Chronic Disease, Chronic Obstructive Pulmonary Disease (COPD), Pharmacotherapy, Respiratory Tract Diseases
Table 1. Large Bronchodilator Trials According to Factors For Interpreting Good Clinical Practice on Design, Results, and Translation

<table>
<thead>
<tr>
<th>Study (trial registry; funding)</th>
<th>Patients (n)</th>
<th>Length of Follow-up</th>
<th>Selection Criteria (Part)</th>
<th>Population</th>
<th>Interventions</th>
<th>Rescue</th>
<th>Prohibited</th>
<th>Allowed bias</th>
<th>Primary outcome</th>
<th>Results</th>
<th>Significance</th>
<th>Focus*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calverley, 2007* (registered; funding from GSK)</td>
<td>6112</td>
<td>3 years</td>
<td>40-80 years old, COPD diagnosis, FEV&lt;sub&gt;1&lt;/sub&gt;: &lt;60% before BD, Reversibility: &lt;10% No respiratory disease, use of oxygen before BD</td>
<td>65 years</td>
<td>75% male 43% smoker</td>
<td>Salmeterol/ Fluticasone Salmeterol Fluticasone Placebo</td>
<td>Albuterol</td>
<td>Long-acting BD, steroids</td>
<td>Short-acting and other BD</td>
<td>Mortality</td>
<td>12.6% vs 13.5% vs 16.0% vs 15.2%</td>
<td>NS</td>
</tr>
<tr>
<td>Calverley et al, 2003 (not registered; funding from GSK)</td>
<td>1465</td>
<td>1 year</td>
<td>FEV&lt;sub&gt;1&lt;/sub&gt;: 25% to 70% before BD, Reversibility: &lt;10% 3 years</td>
<td>63.5 years</td>
<td>72.5% male 51% smoker</td>
<td>Salmeterol/ Fluticasone Salmeterol Fluticasone Placebo</td>
<td>Albuterol</td>
<td>Long-acting β-agonist, steroids</td>
<td>Anticholinergics and theophyllin</td>
<td>FEV&lt;sub&gt;1&lt;/sub&gt; before BD</td>
<td>10% vs 2% vs 2% vs 3%</td>
<td>P &lt; .01</td>
</tr>
<tr>
<td>Tashkin et al, 2008 (registered; funded by BI and Pfizer)</td>
<td>5993</td>
<td>4 years</td>
<td>&gt;40 years, FEV&lt;sub&gt;1&lt;/sub&gt;: &gt;70%, FER: &lt;0.70 No respiratory disease, use of oxygen 6 months</td>
<td>64.5 years</td>
<td>75% male 30% smoker</td>
<td>Spiriva Placebo</td>
<td>—</td>
<td>Short-acting anticholinergics All nonanticholinergics</td>
<td>FEV&lt;sub&gt;1&lt;/sub&gt; decline before and after BD</td>
<td>Before BD: 30 vs 30 mL/yr After BD: 40 vs 42 mL/yr</td>
<td>NS</td>
<td>C</td>
</tr>
<tr>
<td>Niewoehner et al, 2005 (not registered; funded by BI and Pfizer)</td>
<td>1829</td>
<td>6 months</td>
<td>&gt;40 years, COPD diagnosis, FEV&lt;sub&gt;1&lt;/sub&gt;: &lt;60% before BD, No asthma 6 months, cardiac hospital during past year</td>
<td>67.8 years</td>
<td>99% male 30% smoker</td>
<td>Spiriva Placebo</td>
<td>—</td>
<td>Short-acting anticholinergics All nonanticholinergics</td>
<td>%Exacerbation</td>
<td>32.3% vs 27.9% vs 9.5% vs NS</td>
<td>P = .037</td>
<td>D</td>
</tr>
</tbody>
</table>

Continued
Methods
WD and LB conducted a search in both PubMed and Embase until July 31st, 2011, containing primary publications in leading journals with a high impact factor. We included randomized controlled trials with at least 100 participants with COPD, that studied the effectiveness of long-acting bronchodilator treatment. We included trials on bronchodilator effect in COPD populations of large trials, including 1465 to 7376 patients, with a follow-up between 6 and 48 months. The mean proportion of patients with COPD severity was measured by percentage of predicted forced expiratory volume in first second (FEV1). All studies included patients with at least 10 pack-years smoking history, and none of the studies reported significant positive outcomes for the study medication of interest in general, only three of the analyses focused on a statistically significant beneficial effect. A: Acknowledge statistically nonsignificant results for primary outcome, but the focus is on beneficial effect and secondary outcome in main text discussion and conclusion. B: Focus is on secondary outcome in main text discussion. C: Focus is on secondary outcome in result and discussion section of both abstract and main text. D: Acknowledge statistically nonsignificant results for the primary outcome (called “borderline significant”), but focus is on beneficial effect in the abstract. Focus is on inaccurate description of population in main text discussion and conclusion. BD, bronchodilator; BI, Boehringer Ingelheim; COPD, chronic obstructive pulmonary disease; CVD, cardiovascular disease; FER, forced expiratory ratio; FEV1, forced expiratory volume in first second; GSK, GlaxoSmithKline; NS, not significant.

Table 1. Continued

<table>
<thead>
<tr>
<th>Study (trial registry; funding)</th>
<th>Patients (n)</th>
<th>Length of Follow-up (Part)</th>
<th>Selection Criteria</th>
<th>Population</th>
<th>Medication Protocol</th>
<th>Primary outcome Results</th>
<th>Significance</th>
<th>Focus*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vogelmeier et al,8 2011 (registered; funded by BI and Pfizer)</td>
<td>7376</td>
<td>1 year</td>
<td>FEV1 &lt; 70%, FER &lt; 0.70</td>
<td>62.9 years, 74.7% male</td>
<td>Spiriva, Salmeterol</td>
<td>Time to first exacerbation</td>
<td>187 vs 145 days (first fourth of patients)</td>
<td>P &lt; .001</td>
</tr>
</tbody>
</table>

*A: Acknowledge statistically nonsignificant results for primary outcome, but the focus is on beneficial effect and secondary outcome in main text discussion and conclusion. They claim the study is underpowered. B: Focus is on secondary outcome in main text discussion. C: Focus is on secondary outcome in result and discussion section of both abstract and main text. Of many nonsignificant post hoc subgroup analyses, they only state the significant one. D: Acknowledge statistically nonsignificant results for the primary outcome (called “borderline significant”), but focus is on beneficial effect in the abstract. Focus is on an exaggerated effect on one fourth of all patients (a third had an exacerbation), which is not stated in the abstract. Focus is on inaccurate description of population in main text discussion and conclusion. BD, bronchodilator; BI, Boehringer Ingelheim; COPD, chronic obstructive pulmonary disease; CVD, cardiovascular disease; FER, forced expiratory ratio; FEV1, forced expiratory volume in first second; GSK, GlaxoSmithKline; NS, not significant.
always correctly stated the population key characteristics, whereas another used pre-bronchodilator values as primary outcome.

Discussion

Despite the positive tone in the reports of large trials on long-acting bronchodilator therapy in COPD patients, only half of the primary outcomes were statistically significant. Next, reports tend to focus on statically significant outcomes and not necessarily on primary outcomes or outcomes of the whole study population.

Compared with combining results of smaller rigorous trials into meta-analyses, megatrials could provide a small advantage on minimizing confounding by change. However, since large trials increase their participant numbers by reducing protocol rigidness, bias can be introduced that weakens causative interpretations. For instance, in these COPD megatrials, various co-medications were allowed during the study without proper adjustments for it in the analyses. On the other hand, decreased rigidity may provide a generalization of results in daily practice, but only if the study population is representative of the target population to which its results will be applied. Moreover, the clinical relevance of the rather small effects in a possibly biased COPD population that is not representative for daily care should be debated, in particular as meta-analyses rate these trials on their patient numbers mostly.

Most patients with COPD are treated in the community, while the selection of patients for large trials is biased toward referred, hospital cared patients. This, together with the tendency of relying on statistical rather than clinical significance, hampers translation to the large number of patients with COPD in the community. Independent from symptom relief, we would therefore plea for some precaution on the customary prescription of long-acting bronchodilators for the COPD population at large.

References

3. Calverley PM, Rennard SI. What have we learned from large drug treatment trials in COPD? Lancet 2007;370:774–85.