

# Effect of Budesonide by metered dose inhaler with or without spacer & dry powder inhaler on Lung Function

Dilshad Ali Rizvi<sup>1\*</sup>

Mohammad Tariq Salman<sup>1</sup>

Joydeep Sircar<sup>2</sup>

Ali Ahmad<sup>1</sup>

<sup>1</sup>Department of Pharmacology, Era's Lucknow Medical College, Sarfarazganj, Hardoi Road, Lucknow, India. 226003.

<sup>2</sup>Department of Pulmonary Medicine, Era's Lucknow Medical College, Sarfarazganj, Hardoi Road, Lucknow, India. 226003.

## Corresponding Authors:

Dr. Dilshad Ali Rizvi  
Department of Pharmacology,  
Era's Lucknow Medical College,  
Sarfarazganj, Hardoi Road,  
Lucknow, India. 226003. Email:  
dr.dilshadali@yahoo.com.

## Abstract:

**Aims & objective-**To compare the efficacy of Budesonide delivered by metered dose inhaler, metered dose inhaler with spacer and dry powder inhaler on the lung function test parameters.

**Materials and Methods:** This prospective study was undertaken to assess the effect of budesonide administered from fifty patients of chronic stable bronchial asthma were budesonide(400mcg) by metered dose inhaler, metered dose inhaler with spacer and by dry powder inhaler at day 14, 21 and 28 after enrolment respectively under direct supervision. Pulmonary function test was done before and one hour after administration of the drug on each visit.

**Results:** There was no evidence of difference in peak expiratory flow rate (P=0.20), forced expiratory volume in one second (P=0.98), forced vital capacity (P=0.57) and forced expiratory volume in one second and forced vital capacity ratio (P=0.34) was seen after giving budesonide by different devices.

**Conclusion:** Budesonide delivered by metered dose inhaler, metered dose inhaler with spacer and dry powder inhaler have similar effect on lung function in patients of chronic stable bronchial asthma and may be used interchangeably.

**Keywords:** Inhaled Corticosteroids, Drug Delivery Devices, Pulmonary Function Tests, Bronchial Asthma.

## Introduction

Inhaled corticosteroids are the most effective drugs for the treatment of asthma and they represent first-line therapy for all patients with persistent disease, irrespective of disease Severity.

[1] The clinical benefit of inhaled corticosteroids therapy is determined by a Complex interplay between the nature and severity of the disease, the type of drug and its formulation, and characteristics of delivery device together with the patient's ability to use the device correctly. [2] Studies have demonstrated their efficacy in reducing symptom, frequency and severity of asthma exacerbations and asthma mortality. Inhaled corticosteroids are marketed with

different delivery devices, which have different lung deposition properties, in vivo dosage accuracy and dose variability. [3] The major advantage of inhaled therapy is that drugs are delivered directly into the airways producing higher local concentrations with significantly less risk of systemic side effects.

Inhaled medications for asthma are available as pressurized metered dose inhaler, metered dose inhaler with spacer, breath-actuated metered dose inhaler, dry powder inhalers, soft mist inhalers and nebulized or wet aerosols. In most of studies the inhaled corticosteroids for the treatment of bronchial asthma have been administered by one or two of the devices as stated above. To the best of our knowledge there is no Indian study

comparing clinical efficacy of budesonide delivered via metered dose inhaler, metered dose inhaler with spacer and dry powder inhaler in patients of chronic stable bronchial asthma.

With inhaled corticosteroids being the mainstay of anti-inflammatory treatment in asthma, it is necessary to determine the comparative efficacy of different corticosteroids delivered through different inhaler devices. The present study was undertaken to assess the relative efficiency of budesonide administered from different delivery devices to adult patients of chronic stable bronchial asthma as measured by pulmonary function test parameters.

## Materials and Methods

Effect of Budesonide by different delivery devices was studied in patients of chronic stable bronchial asthma attending out patient department of Tuberculosis and Chest Diseases. Individuals of either sex aged 18 years and above, who were residents of the local area and had a history of bronchial asthma for at least 6 months comprised the study unit. Approval for the study from the Institutional ethical committee was obtained and written and informed consent from all patients was taken.

Sample size was calculated to be 36 on the basis of prior observations reported in a previous Study [4] using the formula:  $n = (z_{1-\alpha/2} + z_{1-\beta})^2 (\sigma_1^2 + \sigma_2^2) / d^2$  where  $\sigma_1 = 3.4$ ,  $\sigma_2 = 4.7$ ,  $d = 3.4$ ,  $Z_{1-\alpha/2} = 1.96$ ,  $Z_{1-\beta} = 1.28$ ,  $\alpha = .05$  and  $\beta = 0.1$  (power 90%). But assuming loss to follow up cases to be 30% (10% for each step), the initial recruitment was calculated to be 46.8 which was further rounded off to 50 cases.

## Inclusion criteria

The subjects fulfilling the following criteria were considered to be suffering from chronic stable bronchial asthma as defined by American Thoracic society 1987.[6].

1. History suggestive of bronchial asthma
2. No acute exacerbation (episodes of progressive increase in shortness of breath, cough, wheezing, or chest tightness, or some combination of these symptoms) within the past one month
3. No history of receiving any corticosteroid therapy for past one month
4. Baseline forced expiratory volume in one second (FEV1) less than 80% of predicted value
5. Increase in FEV 1 equal or more than to 12% and peak expiratory flow rate (PEFR) equal or more than to 20% of baseline value 15 minutes after bronchodilator therapy.

## Exclusion criteria

1. Patients with past history of hypersensitivity to budesonide.
2. History of treatment of asthma within four weeks prior to study.
3. Pregnant and lactating females,
4. Subjects with hepatic, cardiac, renal and respiratory disorders and those with an upper respiratory tract or acute sinus infection within four weeks prior to enrollment.
5. Individuals with a smoking history of >10 pack-years and those on immunotherapy who required a change in dosage regimen within 12 weeks prior to enrollment.

**Study design:** Prospective, Open label Single dose of Budesonide 400mcg by metered dose inhaler was given on the second visit (day-14). On the third visit (day 21) single dose of Budesonide 400mcg by metered dose inhaler with spacer was administered. Finally on the fourth visit (day 28) a

single dose of Budesonide 400mcg by dry powder inhaler was given. All study subjects underwent pulmonary function tests before and one hour after drug administration.

After a standardized initial evaluation, which included complete history taking, clinical examination, investigations, asthma symptom score and spirometry, patients were requested to follow up after two weeks and then weekly of two weeks. Each patient was given a card in which as needed salbutamol inhalation was to be mentioned by the patients themselves and they were requested to bring the card along with them when they came after two week. Each patient was given a diary to encircle asthma symptoms.

The severity of Asthma was assessed by symptom score as mentioned by Coverley et al (2005) [7] that included major complains of asthma i.e. (i) shortness of breath, (ii) cough (iii) chest tightness (iv) night time awaken. The individual score of above four parameters were added up to get the cumulative asthma score. Graded scoring system was used to note patients complain and severity.

Spirometry was done at the beginning of study (day-0). Before spirometry it was ascertained patient had not taken inhaled  $\beta$  (salbutamol) therapy for at least 6 hours, theophylline therapy for at least 24 hours, and antihistamine therapy for at least 48 hours and coffee for at least 4 hours. Spirometry was performed with standard techniques and evaluated for validity according to American Thoracic Society criteria (1995) [5] using Medspiror (Medsystems Private Limited, Chandigarh). At least three spirometry maneuvers were done and highest FEV1 value was noted. Patients who had FEV1, less than 80% of predicted value were administered inhaled salbutamol 200mcg by nebulizer. Fifteen minutes after

salbutamol administration spirometry was repeated and those patients who had an increase of at least 12% absolute FEV1 and at least 20% PEFr were labeled as suffering from bronchial asthma and enrolled in the study. Thus in all, patients had to visit the department for 4 times including nomination, registration and 3 follow up visits.

Drug was administered under direct supervision by standard technique described by CMAJ(1999).

### Statistical analysis

Data entry and statistical analysis was done using statistical package of social science (SPSS) software (version 17.0). pre-treatment and post treatment value were compared by student paired "t" test, pulmonary function test parameters on different days were compared by ANOVA followed by post hoc turkey's test. Asthma symptoms scores were compared by kruskalwallis test were used. P values less than 0.05 were considered significant.

### Results

Initially 50 patients were enrolled in the study out of which, 3 did not turn up after second visit and 2 did not turn up after third visit. None of the patients experienced an acute exacerbation of asthma during the study period. Thus finally 5 patients were excluded due to loss to follow up and the data of the remaining 45 subjects (27 males and 18 females) was analyzed (Figure 1). Twenty four (53.3%) individuals were aged between 18-40 years, 17 (37.7%) individuals were aged between 41-60 years and 4 (8 individuals were aged between 61 mean age of the patients was found to be 42 years.

Mean asthma scores calculated from diary card entries varied between 1.97 to 2.09 on days of visits. There was no significant difference in patient's asthma symptom score per week at day 0, 14, 21 and 28 ( $P>0.05$ ). Since there was no significant change in pulmonary function test Parameters (before the giving budesonide) at day-14, day-21, day-28, which shows that the patients were suffering from chronic stable bronchial asthma and there was no evidence of significant modification in the disease process during the course of the study. No significant Change in the asthma symptom scores and use of rescue medication during the study periods also shows that there was no acute exacerbation and the patients were stable.

Pretreatment values of peak expiratory flow rate varied between 31- 48 %, 33- 50 % and 33- 48 % before giving budesonide by metered dose inhaler (day-14), metered dose inhaler with spacer (day-21) and dry powder inhaler (day-28) respectively. There was no significant difference in PEFR values at day-14, 21 and 28, before giving the drug by different devices ( $P>0.05$ ). [Table-1]

Pretreatment values of forced expiratory volume in 1 second varied between 60 -77%, 62 - 75% and 58 - 77% before giving budesonide by metered dose inhaler (day-14), metered dose inhaler with spacer (day-21) and dry powder inhaler (day-28) respectively. There was no significant difference in FEV<sub>1</sub> values at day-14, 21 and 28 before giving the drug by different devices ( $P>0.05$ ). [Table-2]

Pretreatment values of forced vital capacity varied between 82 - 101%, 84 -102% and 84 - 103% before giving budesonide by metered dose inhaler (day-14), metered dose inhaler with spacer (day-21) and dry powder inhaler (day-28) respectively. There was no significant difference in

FVC values at day-14, 21 and 28 before giving the drug by different devices ( $P>0.05$ ). [Table-3]

Pretreatment values of FEV<sub>1</sub>/FVC varied between 0.70 - 0.83%, 0.66 - 0.83% and 0.66- 0.83% before giving budesonide by metered dose inhaler (day-14), metered dose inhaler with spacer (day-21) and dry powder inhaler (day-28) respectively. There was no significant difference in FEV<sub>1</sub>/FVC values at day-14, 21 and 28, before giving the drug by different devices ( $P>0.05$ ). [Table-4]

One hour after giving budesonide by metered dose inhaler (day-14), metered dose inhaler with spacer (day-21) and dry powder inhaler (day-28) there was highly significant increase in PEFR ( $P<0.001$ ). The percentage change in PEFR was highest after giving budesonide dry powder inhaler (33 - 50%), followed by metered dose inhaler with spacer (36 - 53 %) and metered dose inhaler (36 - 50 %). However there was no significant difference in the PEFR after giving budesonide by any of the devices ( $P>0.05$ ).

One hour after giving budesonide by the different devices at day-14, 21 and 28, there was highly significant increase in FEV<sub>1</sub> ( $P<0.001$ ). The post treatment values of FEV<sub>1</sub> ranged between 63 - 81%, 64 -79% and 66 - 82% by metered dose inhaler, metered dose inhaler with spacer and dry powder inhaler respectively, the difference being statistically insignificant ( $P>0.05$ ).

One hour after giving budesonide by different devices at day-14, 21 and 28, there was highly significant increase in FVC ( $P<0.001$ ). The percentage change in FVC ranged between 87 - 105%, 86 -106% and 87 - 107% by metered dose inhaler, metered dose inhaler with spacer and dry powder inhaler respectively, the difference being statistically insignificant ( $P>0.05$ ).

One hour after giving budesonide by different devices at day-14, 21 and 28 there was highly Significant increase in FEV1/FVC ( $P < 0.001$ ). The percentage change in FEV1/FVC ranged between 0.71 - 0.85, 0.67 - 0.84% and 0.67-0.84% by metered dose inhaler, metered dose inhaler with spacer and dry powder inhaler respectively, the difference being statistically insignificant ( $P > 0.05$ ).

The pulmonary function parameters showed a highly significant increase one hour after giving budesonide by any of the devices evaluated. There was no significant difference in post treatment values of peak expiratory flow rate ( $P = 0.20$ ), forced expiratory volume in one second ( $P = 0.98$ ), forced vital capacity ( $P = 0.57$ ) and forced expiratory volume in one second and forced vital capacity ratio ( $P = 0.34$ ) after giving budesonide by metered dose inhaler, metered dose inhaler with spacer and dry powder inhaler respectively at day 14, 21 and 28. This shows a similar efficacy of budesonide delivered via the different devices studied.

The pulmonary function parameters showed a highly significant increase one hour after giving budesonide by any of the devices evaluated. There was no significant difference in post treatment values of peak expiratory flow rate ( $P = 0.20$ ), forced expiratory volume in one second ( $P = 0.98$ ), forced vital capacity ( $P = 0.57$ ) and forced expiratory volume in one second and forced vital capacity ratio ( $P = 0.34$ ) after giving budesonide by metered dose inhaler, metered dose inhaler with spacer and dry powder inhaler respectively at day 14, 21 and 28. This shows a similar efficacy of budesonide delivered via the different devices studied.

## Discussion

Our study compared the effect budesonide delivered via metered dose inhaler, metered dose inhaler with spacer and by dry powder inhaler on lung functions and revealed that these devices have a similar effect on the lung function in patients of chronic stable bronchial asthma.

One hour after giving budesonide by metered dose inhaler (day-14), metered dose inhaler with spacer (day-21) and dry powder inhaler (day-28) there was highly significant increase in PEFR in our study.

Several studies have demonstrated an increase in peak expiratory flow rate after giving budesonide by nebulizer, metered dose inhaler, metered dose inhaler with spacer and dry powder inhaler over a period of 1 to 12 weeks.[9-13]

No significant difference in the PEFR was found after giving budesonide by any of the different devices used in our study which is in agreement with the study of Bisgaard et al (1998) [9] that compared the effect of budesonide given as nebulized suspension verses metered dose inhaler in adult asthmatics. Spirometry at their clinic revealed no statistically significant difference between the treatments. Engel et al (1989) [10] also demonstrated that there was no significant difference in peak expiratory flow rate at clinic and evening peak exploratory flow rate after giving budesonide by metered dose inhaler or dry powder inhaler, however morning peak expiratory flow rate found from patient's diaries showed significantly higher values in the group receiving budesonide through dry powder inhaler. Reason of different effects of delivery devices on morning evening peak expiratory flow rate needs to be further investigated.

One hour after giving budesonide by metered dose inhaler (day-14), metered dose inhaler with spacer (day-21) and dry powder inhaler (day-28) there was a highly significant increase in FEV<sub>1</sub> in our study. Kerwin et al (2008)[11] observed a significant increase in FEV<sub>1</sub> when budesonide was given by dry powder inhaler as compared to placebo. There was no significant difference found in the FEV<sub>1</sub> after giving budesonide by any of the devices used in our study. Engel et al (1989) [10] compared inhaled budesonide delivered either via pressurized metered dose inhaler or turbuhaler and found that there was no significant difference in FEV<sub>1</sub> between the two treatments. Bisgaard et al (1998) [9] compared the efficacy of budesonide as a nebulized suspension versus pressurized metered dose inhaler in adult asthmatics and revealed no statistically significant difference between the treatments.

One hour after giving budesonide by metered dose inhaler (day-14), metered dose inhaler with spacer (day-21), dry powder inhaler (day-28) forced vital capacity also increased significantly. Although the percentage change in forced vital capacity was highest with metered dose inhaler followed by metered dose inhaler with spacer and dry powder inhaler but there was no significant difference in the FVC after giving budesonide by any of the devices. Engel et al (1989) [10] compared inhaled budesonide delivered via pressurized metered dose inhaler and turbuhaler and found no statistically significant differences in FVC.

One hour after giving budesonide by metered dose inhaler (day-14), metered dose inhaler with spacer (day-21) and dry powder inhaler (day-28) there was highly significant increase in forced expiratory volume in one

second and forced vital capacity ratio (FEV<sub>1</sub>/FVC). There was no significant difference found in the FEV<sub>1</sub>/FVC after giving budesonide by any of the devices. Previous studies on inhaled budesonide by different devices in patients of chronic stable bronchial asthma have not reported the effect on FEV<sub>1</sub>/FVC.

The present study found no significant differences on spirometric variables after giving budesonide via metered dose inhaler, metered dose inhaler with spacer and dry powder inhaler. They may be used interchangeably depending on availability, cost and compliance of the patients. We conclude that budesonide delivered by different devices (metered dose inhaler, metered dose inhaler with spacer and dry powder inhaler) have similar effect on lung function in patients of chronic stable bronchial asthma and may be used interchangeably.

### Acknowledgement:

We are thankful to Dr Zeeshan Haider Zaidi Assistant Professor / biostatistician, Department of Community Medicine, Era's Lucknow Medical College Lucknow for his help in statistical analysis.

**Table 1:** Effect on Peak Expiratory Flow Rate (PEFR) (Predicted %) after giving Budesonide by Different Devices

Drug Delivery Device		Pre-treatment Mean (Confidence Interval)	Post-treatment Mean (Confidence Interval)
Metered Dose Inhaler		40.35 (39.12-41.59)	43.29 (42.00-44.57)
Metered Dose Inhaler with Spacer		41.07 (39.70-42.43)	43.97 (42.74-45.21)
Dry Powder Inhaler		40.80 (39-56-42.04)	44.82 (43.67-45.96)
ANOVA	F value	0.31	1.6
	P value	0.73	0.20

**Table 2:** Effect on Forced Expiratory Volume in 1 second (FEV<sub>1</sub>) (Predicted %) after giving Budesonide by Different Devices

Drug Delivery Device		Pre-treatment Mean (Confidence Interval)	Post-treatment Mean (Confidence Interval)
Metered Dose Inhaler		67.60 (66.15-69.4)	72.89 (71.31-74.46)
Metered Dose Inhaler with Spacer		68.20 (67.06-69.34)	73.4 (71.64-74.44)
Dry Powder Inhaler		68.78 (67.06-70.49)	73.04 (71.21-74.87)
ANOVA	F value	0.66	0.01
	P value	0.51	0.98

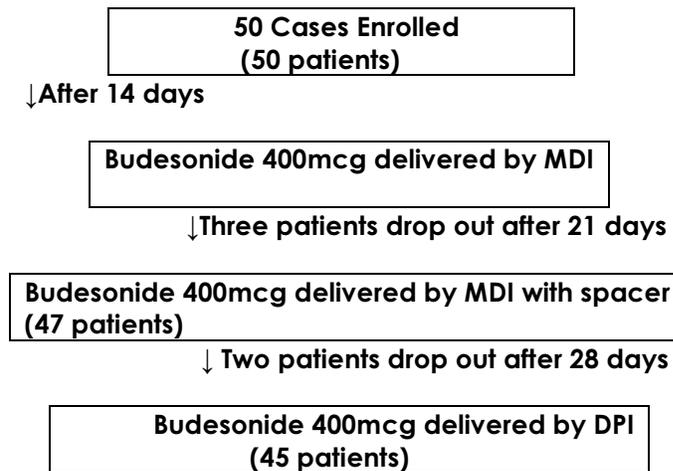
**Table 3:** Effect on Forced Vital Capacity (FVC) (Predicted %) after giving Budesonide by different devices

Drug Delivery Device		Pre-treatment Mean (Confidence Interval)	Post-treatment Mean (Confidence Interval)
Metered Dose Inhaler		91.80 (89.64-93.96)	96.02 (93.66-98.38)
Metered Dose Inhaler with Spacer		92.15 (90.62-93.69)	97.04 (95.15-98.94)
Dry Powder Inhaler		93.55 (91.33-95.78)	97.67 (95.23-100.90)
ANOVA	F value	0.87	0.56
	P value	0.41	0.57

**Table 4:** Effect on FEV<sub>1</sub>/FVC (Predicted %) after giving Budesonide by different devices

Drug Delivery Device		Pre-treatment Mean (Confidence Interval)	Post-treatment Mean (Confidence Interval)
Metered Dose Inhaler		0.73 (0.72-0.75)	0.76 (0.75-0.78)
Metered Dose Inhaler with Spacer		0.74 (0.73-0.75)	0.75 (0.74-0.76)
Dry Powder Inhaler		0.72 (0.72-0.74)	0.73 (0.73-0.76)
ANOVA	F value	0.17	1.06
	P value	0.85	0.34

**Figure 1:** Study Design and Execution



## References

- 1) Global Initiative for Asthma. NHLBI/WHO workshop report. Global strategy for asthma management and prevention. National Institutes of Health, National Heart, Lung, and Blood Institute. Revised 2002. Publication no. 02-3659.
- 2) Barnes PJ, Seidenberg J, Magnan A, Pedersen S, Dal Negro R, Crompton GK, Virchow JC. Importance of inhaler devices in the management of airway disease. *Respiratory Medicine* 2008; 0954-6111.
- 3) Thorsson L, Geller D. Factors guiding the choice of delivery device for inhaled corticosteroids in the long-term management of stable asthma and COPD: focus on budesonide. *Resp Med* 2005; 99: 836-49.
- 4) Dane E, Funda C, Esra K U, Eser G Y, Mehmet K, Ercument E, Oktay G. Clinical effectiveness of nebulised budesonide in the treatment of acute asthma attacks. *Tuberkulozve Torak Dergisi*. 54(2): 128-136, 2006.
- 5) Standardization of spirometry, 1994 update. American Thoracic Society. *Am J Respir Crit Care Med* 1995; 152(3):1107-36.
- 6) American Thoracic Society: Standards for the diagnosis and care of patients with chronic
- 7) Obstructive pulmonary disease and asthma. *AmRevRespir Dis* 1987: 136:225-43.

- 8) Calverley P, Pauwels R, Lofdahl CG, Svensson K, Higenbottam T, Carlsson IG, Stahl E. Relationship between respiratory symptoms and medical treatment in exacerbations of COPD. *Eur Respir J* 2005; 26: 406-413.
- 9) Census of India: Provisional Population Total (Paper 2001). Registrar and Census Commissioner for India, New Delhi, 2001.
- 10) Bisgaard H, Nikander K, Munch E. Comparative study of budesonide as a nebulized suspension vs pressurized metered dose inhaler in adult asthmatics. *Respiratory Medicine* 1998; 92:4449.
- 11) Engel T, Heinig JH, Malling HJ, Scharling B, Nikander K, Madsen F. Clinical comparison of inhaled budesonide delivered either via pressurized metered dose inhaler or Turbuhaler. *Allergy* 1989; 44:220-225.
- 12) Kerwin EM, Pearlman DS, De Guia T, Carlsson LG, Gillen M, Uryniak T, Simonson SG. Evaluation of efficacy and safety of budesonide delivered via two dry powder inhalers. *Curr Med Res Opin* 2008; 24(5):1497-510.
- 13) Morice AH, Hochmuth L, Ekelund J, Thoren A, Puterman AS. Comparable long term safety and efficacy of a novel budesonide/formoterol pressurized metered dose inhaler versus budesonide/formoterol Turbuhaler in adolescents and adults with asthma. *Pulm Pharmacol Ther* 2008; 21(1):32-9.
- 14) Volovitz B. inhaled budesonide in the management of acute worsening and exacerbations of asthma: a review of the evidence. *Respir Med* 2007 Apr; 101(4): 685-95.

**Article History:** .....

Date of Submission: 13-12-2013

Date of Acceptance: 29-12-2013

Conflict of Interest: NIL

Source of Support: NONE

**SJR** SCImago  
Journal & Country  
Rank

Powered by  
**SCOPUS™**