Anti-inflammatory therapy

Oral steroids in cystic fibrosis

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Background

In CF airway obstruction and recurrent respiratory infection lead to inflammation, long-term lung damage, respiratory failure and death. Current evidence suggests that inflammation in CF occurs early in life and may contribute to lung damage. This is the rationale for the use of anti-inflammatory therapy in CF (Pressler T, 2011). Anti-inflammatory drugs for CF lung disease appear to have beneficial effects on disease progression. These agents include oral corticosteroids and ibuprofen, as well as azithromycin, the latter in addition to its antimicrobial effects, also possesses anti-inflammatory properties. Adverse effects limit therapy with oral corticosteroids and ibuprofen.

Issues

1. To assess the effectiveness of long-term use of oral corticosteroids (OC) in:
   - reducing the number of days of intravenous antibiotics for respiratory exacerbations;
   - reducing the need for hospital admission for respiratory exacerbations;
   - improving or preventing the decline of lung function;
   - improving exercise tolerance;
   - improving nutritional status;
   - improving quality of life;
   - improving survival.

1. To identify any adverse event associated with the use of OC including changes in cushingoid appearance, growth suppression, diabetes mellitus, cataracts, osteoporosis and the onset of opportunistic infection.

What is known

1 CDSR updated 2015 was available to assess the effectiveness of OC on lung function in CF for a long-term use and few studies were published on this topic.

Of eleven studies identified, three (354 participants) were included: two with four-year follow up and one with 12-weeks follow up. No predefined outcomes were found; common outcomes were examined at different time-points. Meta-analyses were not possible.

1. Regarding to the first explored issues a few data are available on the effect of OC on the decline of lung function in CF. On the basis of four reviewed trials with a total of 378 participants followed from 1 year to 19.5 years at all stages of lung disease, one for six weeks, one for 12 weeks and two with four year follow up, OC from 1mg/kg to 2 mg/kg (prednisolone equivalent) given every day seemed to slow the advance of lung disease. In only one RCT study, oral corticosteroids at prednisolone-equivalent dose of 1 mg/kg alternate days slowed progression of lung disease; at two and four years, % predicted FEV1 in the 1 mg/kg group changed significantly more than in the placebo group (P < 0.02). These data were not confirmed when the 2 mg/kg treated group was evaluated during the first two years, compared to placebo group. Linear growth retardation was observed from six months in the 2 mg/kg alternate days prednisolone group and from 24 months in the 1 mg/kg alternate days prednisolone group.

2. Related to issue 2 serious adverse effects were reported such as cataracts and the slowing of growth at higher doses, but not all the same adverse events were reported in the four studies. Follow-up data show that catch-up growth started two years after treatment stopped. Alternate-day treatment with oral corticosteroids may have impaired growth until adulthood in boys.

Current evidence suggests that oral corticosteroids at a prednisolone equivalent dose of 2 mg/kg on alternate days is effective but should not be used due to the high risk of occurrence of important side effects. A dose of 1 mg/kg on alternate days might be considered for up to 24 months, but close attention to the occurrence of adverse effects is warranted.

Unresolved questions

OC at prednisolone-equivalent dose of 1 to 2 mg/kg alternate days appear to slow progression of lung disease in CF; benefit should be weighed against occurrence of adverse events. Risk-benefit analysis of low-dose alternate days corticosteroids is important and the short-term use of oral corticosteroids should be better evaluated.

However, the two outcomes common to all four studies were lung function and adverse events. Related to the other issues exercise tolerance, number of days of intravenous antibiotics for respiratory exacerbations, quality of life, nutritional status and survival were not
entirely explored by RCTs during OC therapy.

Further trials should consider OC in conjunction with other conventional therapies by targeting individuals who could benefit from OC. Multicenter clinical trials are needed to follow-up several adverse effects related to early treatment by OC, such as osteoporosis and diabetes in the long term therapy.

No conclusive data are available regarding the effect of intravenous corticosteroids on clinical outcomes.

Keywords

Anti-Inflammatory Agents; Steroids;