Never Change a Winning Team: Patient and Inhalation Device

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In this issue of *Respiration*, Bjermer [1] reviewed the importance of continuity in the choice of the inhaler device for patients with asthma and chronic obstructive pulmonary disease. An inhaler device is a major component in the successful and cost-effective therapy of chronic obstructive lung disease. Thomas et al. [2] reported in a retrospective matched cohort study using the UK General Practice Research Database that the device delivering inhaled corticosteroids had been switched in nearly one third of the patients, mainly from dry powder to metered-dose inhalers. The likelihood of asthma control among switched versus control patients was significantly lower. There may have been several causes for changing the device. Misuse of the device was apparently not the main reason. In this case, switching the device would have improved asthma control.

However, the more devices with inhaled corticosteroid or fixed long-acting β_2 -agonist/inhaled corticosteroid combinations became available, the higher the pressure to switch the inhaler to cheaper devices. In some countries, a substitution is mandated by current regulations or health insurance companies. It is known that doctors and nurses have difficulties teaching the correct use of the inhalation device [3]. The increasing number of devices will not reduce this problem.

Different doctors may prescribe devices not knowing the patient's health record in detail. This results in a mix-

up of devices, which enhances the risk of prescribing an inappropriate device that does not meet the individual's needs and may lead to misuse. Further, the number of devices and probably switching the device without education and consent of the patient reduces adherence. Patient satisfaction with their device was strongly correlated with compliance in a study performed by Small et al. [4]. Matching patient and device in an individual setting seems to be one of the most challenging aspects in inhalation therapy.

It is important to teach patients the correct use of their inhalation device and to take the patients' preferences into account. However, in addition, we have to improve the education of health care professionals. This may result in a better adherence of patients to therapy [5].

It is still unknown which level of adherence is needed to achieve adequate disease control in asthma. Patients may accept a lower level of symptom control. A certain amount of symptoms will encourage patients to use preventive therapy. The role of intermittent therapy in controlled asthma has to be investigated. In a recent study involving 8,000 patients with asthma, it was shown that less than 50% took their preventive medication regularly and in only 47% has the correct use of the inhaler been checked [6]. An important information was that patients did not like to be labeled as sick. Thus, patients may refuse therapy when they are asymptomatic because they do not like to be reminded of their chronic disease.

To summarize, the inhaler device should not be switched in controlled disease without any need. Continuity compared with an excellent education of patients and prescribers will result in a successful therapy. We should keep in mind that the patients' behavior should not be adapted to rigid guidelines with exaggerated goals: guidelines have to meet the patients' requirements and fit into their daily life.

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During the last 3 years, Peter Haidl has received honoraria for attending advisory boards or giving lectures for the following companies: AstraZeneca, Astellas, Berlin-Chemie, Boehringer Ingelheim, Chiesi, GlaxoSmithKline, Forest companies, Mundipharma, Novartis, Nycomed and Teva.

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