LETTERS TO THE EDITOR

Debating pharmacological options for dyspnoea relief; the need for full, accurate and balanced critical appraisal of the evidence

To the editor,

We read with interest the review on strategies to relieve dyspnoea in patients with advanced chronic respiratory disease by Ambrosino and Fracchia.1 Given the clinical need for pharmacological options for dyspnoea relief, we would like to comment on some important aspects that we feel merit further clarification.

The review comments on inhaled furosemide as a potential drug for relieving dyspnoea and refers to our RCT in healthy volunteers2 which showed significant relief of experimentally-induced air hunger. The review stipulates that this was "a finding not confirmed later even at higher doses."3 The comment is misleading, implying that higher-dose studies were completed subsequent to ours and that the findings were incongruous. Our study2 was published after the higher-dose studies. The controlled delivery of 80 mg was associated with greater air hunger relief compared to what we found with uncontrolled delivery of 40 mg (mean ± SE: −17 ± 3 vs −11 ± 5%VAS). However, the greater relief in the higher-dose study was offset by a larger placebo effect (−13 ± 4 vs −2.5 ± 4%VAS). The enhanced placebo effect in the higher-dose study can be explained by differences in study design.

While there is high variability in dyspnoea relief in all published studies of inhaled furosemide, there is potential for it to form a viable treatment option for the most unpleasant form of dyspnoea if the sources of variability are unravelled. Potential sources of variability include, i) site of drug deposition in the lungs ii) rate of extinction from the lungs iii) lack of information on the quality of dyspnoea rated iv) use of a dyspnoea model that is not focussed on 'air hunger'. More research with inhaled furosemide is justified given that it is safe, inexpensive and underpinned by a defined physiological mechanism of action.

The discussion by Ambrosino and Fracchia on the use of opioids for dyspnoea relief is also misleading and fails to paint a balanced picture. The authors have ignored the opioid crisis that has killed over ¾ million Americans since 1999.4 They have not considered the absence of long-term studies of opioid efficacy or safety.5 In most people, opioid efficacy is high in the short term but diminishes over 6 weeks to 3 months. The resultant dose escalation increases risk of adverse events with no improvement in symptoms.5 We suggest extreme caution is necessary for prescription of opioid medication for breathlessness because, i) opioids increase risk for death in people with lung conditions6 ii) people with anxiety/depression are more likely to have diminished opioid response to pain,5 and breathlessness,6 but also are more likely to have problems with dependency and failure to wean off opioids.

Finally the author’s assertion that "Relief of dyspnoea [...] is a human right" echoes sentiments expressed in the mid 1980’s that were used to justify using opioids for all kinds of pain,7 leading to the opioid crisis we are in today. It is preposterous to portray those who harbour legitimate concerns about opioid safety as human rights violators when the debate is not fuelled by a balanced appraisal of the evidence.

Statement of ethics

The authors have no ethical conflicts to disclose.

Funding

The authors have not received any funding specifically for this correspondence.

Author contributions

All authors contributed equally to this correspondence.

Conflict of interest

KP has acted as a consultant for Nektar Therapeutics. The work for Nektar has no bearing on the contents of this manuscript. KP is named as a co-inventor on a provisional UK patent application titled "Use of cerebral nitric oxide donors in the assessment of the extent of brain dysfunction following injury".

References


Crown Copyright © 2019 Published by Elsevier España, S.L.U. on behalf of Sociedade Portuguesa de Pneumologia. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).
Strategies to relieve dyspnoea in patients with advanced chronic respiratory diseases. A narrative review. Authors’ reply

"I speak not to disprove what Brutus spoke, But here I am to speak what I do know". 

We thank Grogono et al. for their interest in our review on management of dyspnoea in patients with advanced respiratory diseases. Breathlessness requires much more attention by clinicians and researchers, as a major health problem around the world for millions of people and their letter may contribute to the discussion.

Inhaled furosemide. Grogono et al. give more details of their study in normal volunteers as well as of other studies. We fully agree with their conclusion that "More research with inhaled furosemide is justified". That's why in our review we concluded that "Based on available data, its (nebulised furosemide – ) use for the routine management of dyspnoea in terminal patients is still either controversial or not indicated." Indeed we are unaware of any guideline recommending the use of inhaled furosemide in patients with advanced respiratory diseases.

Opioids. Practitioners and researchers have paid greater attention to management of pain than dyspnoea, and patients with end-stage respiratory diseases are less likely to undergo palliative care than patients with cancer. The controversy on the use of opioids in respiratory diseases is long standing, and we don’t disprove what anyone spoke, we just speak what we do know. Evidence based international guidelines recommend the use of opioids in appropriate doses, formulations and schedules of administration in patients with advanced chronic respiratory diseases, but we understand authors’ concern about potential long-term adverse effects, lack of effectiveness or risk of addiction. However, we described evidence based management of patients with advanced or end-stage respiratory diseases with poor short-term prognosis and life expectancy which would be probably not long enough to develop such potential long-term side effects.

Nobody denies that respiratory depression is a predictable adverse effect from a significant opioid overdose, while we need further clinical trials to better individualize treatment. Grogono et al. blame us for ignoring the "opioid crisis" quoting a paper on "Opioid Overdose" induced by illegal use or painkillers and not including even once the words "dyspnoea" or breathlessness: Overdose in medicine means malpractice and this is not the case of guidelines. "Illeg- al use or painkillers do not refer to the issue of our review. As a matter of fact our review underlined the "need to be aware of and treat adverse effects" while suggesting a therapeutic escalation exploiting all available pharmacological and non pharmacological tools described in the review. Finally nobody portrayed "those who harbour legitimate concerns about opioid safety as human rights violators", but we do think that avoiding all unpleasant and distressful symptoms, not only pain, in terminal conditions is a human right. Whoever has treated or even only seen an end-stage dyspnoeic patient with pulmonary fibrosis asking for help, knows what we are talking about.

In conclusion Grogono et al. criticize us for lack of "full, accurate and balanced critical appraisal of the evidence" just because they disagree with some of our evidence based ideas (or what they attribute to us) but we could not agree more with their recommendation. In our (unfortunately, ...) long life as researchers and clinicians we have always applied that principle, as is the case of this review, however in all scientific controversies with our peers we have