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Pharmacotherapy

Severe asthma and eligibility for biologics in a Brazilian cohort

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Results

From 544 patients in the cohort, 531 (97.6%) were included and 172 (32.4%) were identified as SA patients according to the ERS/ATS 2014 modified criteria. Of these 172 patients, 69 (40.1%) were ineligible for any of the biologicals approved for asthma (omalizumab, mepolizumab, reslizumab and benralizumab), 60 (34.9%) patients were eligible for one of the biological therapies, and 10 (5.8%) patients were eligible for all biological therapies.

Conclusions

More than half of patients with SA were eligible for biologic therapy in our study, but none of them received this form of treatment. Almost half of them were not eligible to any of the approved biologics, however. The variability and overlap in patients' eligibility highlight the importance of evaluating each patient individually for a more personalized treatment approach. While there is a need to increase access for some of those eligible that may really need a biologic treatment, continuous efforts are required to develop alternatives to those who are not eligible.

Keywords: [Biological therapy](#) [biomarkers](#) [personalized medicine](#) [anti IgE](#) [IL5](#) [IL5 receptor](#)

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hospitalizations, contributing to work and school absenteeism, use of multiple drugs to control the disease, higher healthcare resource utilization and higher mortality risk (1,7).

To better understand and treat the extensive heterogeneity of asthma, many expert groups have proposed distinctive classifications of SA (7-11), with the goal of advancing research and treatment paradigms toward precision medicine. In recent years, much research has led to the identification of SA phenotypes wherein specific biological pathways and mechanisms (endotypes) are being identified to explain the observable properties of the phenotypes, and improving the future prospects for these difficult-to-treat patients (12-14).

In this scenario, biologics have emerged as promising personalized medicines in the treatment of SA. Humanized monoclonal antibodies against immunoglobulin E (IgE) to treat severe allergic asthma, anti-interleukin-5 (IL-5) and anti-IL5 receptor (IL-5R) for severe eosinophilic asthma, have recently entered the clinic as approved therapies (12-14). The addition of a biologic therapy in appropriate patients diagnosed with SA can lead to more effective control of the underlying inflammation and improve some asthma-related outcomes, such as number of exacerbations, quality of life and lung function (12-15). However as new biologicals come forward it is important to identify the characteristics of SA patients who would most benefit from each therapy to achieve better outcomes.

In Brazil, a national asthma program was implemented in 2010, whose main goal was to improve the quality of life of patients, in particular in the poorest regions of the country. In Salvador, a city in the state of Bahia, a research program was implemented to study the prevalence of asthma and asthma-related outcomes in children and adolescents. The program provided educational and health services to the community, and the results of the study were published in a scientific journal. The study was conducted in a city with a high prevalence of asthma, and the results showed that the program was effective in reducing the frequency of asthma exacerbations and improving the quality of life of the patients. The study was conducted in a city with a high prevalence of asthma, and the results showed that the program was effective in reducing the frequency of asthma exacerbations and improving the quality of life of the patients.



Study design and study population

This is an analysis of the database of the ProAR Cohort ([17](#)), which comprises 544 adult patients (≥ 18 years old) with SA according to previous definitions of the Education Prevention Program – Practical guide for the diagnosis and management of asthma/NHLBI-NIH (1997) ([18](#)), and that were included in a case-control study conducted from 2013–2015 ([19](#)). Patients with chronic conditions such as COPD, structural changes of the lungs and pregnancy were excluded. Details and results of the case-control study have been published previously ([19](#)).

In the present study, patients were reclassified using modified criteria of the ERS/ATS Severe Asthma Task Force 2014 (7) as this was the definition used for consideration for treatment with SA biologicals. The ERS/ATS criteria use a history of ICS or oral steroids in the previous 12 months to classify SA. We were limited in having 6 months' medical history available, therefore we describe our analysis according to modified ERS/ATS criteria. Medical records about prescribed asthma medications 6 months prior to starting the case-control study were used to reclassify the patients. Sociodemographic and clinical characteristics, inflammatory markers and the asthma control (Asthma Control Questionnaire (ACQ-6) and GINA asthma symptoms control questionnaire (2012)) collected on the previous conducted case-control study were reassessed in order to characterize the SA ProAR Cohort, as described below.

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period, it was assumed that the dose had not changed since the previous prescription. Sociodemographic and clinical characteristics were described for the SA patients identified through the ERS/ATS 2014 modified definition as a post-hoc analysis. The ERS/ATS 2014 criteria was used as it uses higher ICS doses in its definition than the GINA 2017 criteria, and thus it may better identify SA patients at maximum bronchodilation. Results are descriptive and no statistical hypothesis tests were applied. Continuous variables were expressed as mean and standard deviation, and categorical ones as absolute and relative frequencies. All analyses were performed using SPSS version 24.

Results

In the ProAR database, 531 of the 544 patients consented to the use of their data in the analysis. Of these 531 patients, 172 (32.4%) were classified as SA by the ERS/ATS 2014 modified criteria. The group was predominantly female (84.3%) with a mean (standard deviation (SD)) age of 53 (12) years. Most of the patients defined their ethnicity as “mixed”, had attended elementary school or high school, had a low family income and were overweight or obese (Table 2). With respect to the clinical characteristics observed among these 172 patients with modified ERS/ATS 2014 SA, all patients reported having at least one respiratory symptom, 170 (98.8%) reported having asthma and 169 (98.2%) reported having allergic rhinitis (96.5%).

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Table 3. Description of inflammatory markers in severe asthma from the Brazilian ProAR Cohort patients according to ERS/ATS 2014 definition modified.



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A high proportion of patients had poor asthma control; 55.8% of the patients had uncontrolled asthma according to ACQ-6 scores and 36.0% were classified as “uncontrolled” according to the GINA questionnaire. Approximately 78% of the SA patients had at least one exacerbation in the last year, 15% reported three exacerbations and 22% had five or more exacerbations reflecting the poor asthma control in this population ([Table 4](#)).

Table 4. Assessment of asthma control and number of self-reported exacerbations in severe asthma (SA) from the Brazilian ProAR Cohort patients according to ERS/ATS 2014 definition modified.



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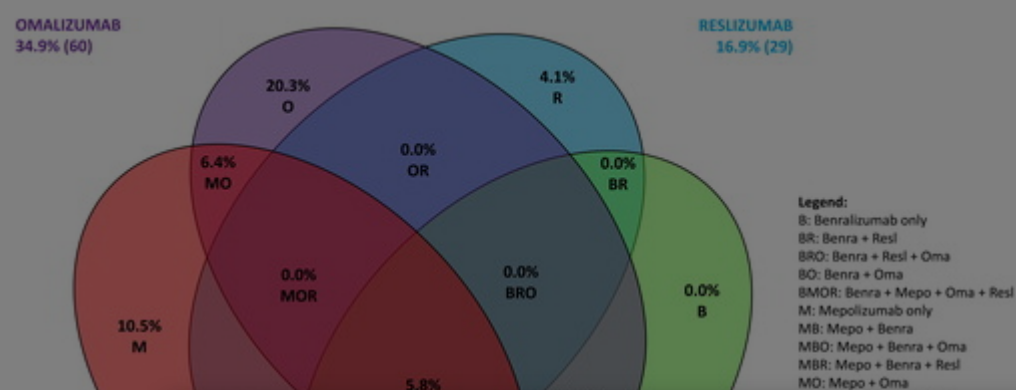


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The frequency of patients eligible for the different biological therapies are shown in Figure 1; 69 of the 172 SA patients (40.1%) were not eligible to any biologicals approved in Brazil. For the remaining patients, 60 (34.9%) were eligible for omalizumab, 61 (35.5%) were eligible for mepolizumab, 32 (18.6%) for benralizumab and 29 (16.9%) for reslizumab. Only 10 (5.8%) patients were eligible for all 4 therapies, and importantly 60 (34.9%) were only eligible for only one of the therapies alone. For patients who were only eligible for a single biological therapy, 35 (20.3%) patients were eligible for omalizumab alone, 7 (4.1%) for reslizumab alone and 18 (10.5%) for mepolizumab alone. 6.4% were eligible for both mepolizumab and omalizumab, 3.5% were eligible for both mepolizumab and benralizumab, 7% were eligible for mepolizumab, benralizumab and reslizumab, 2.3% were eligible for mepolizumab, benralizumab and omalizumab.

Figure 1. Frequency of eligible patients for biological therapy for patients with severe asthma from the Brazilian ProAR Cohort according to ATS/ERS 2014 criteria modified.



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Our study showed that the eligibility for the different biologics can be quite varied, even for biologics potentially targeting the same mechanism, e.g.IL5. Of the 103 patients eligible for biologics, only 10 patients were eligible for all 4 therapies that we examined. As expected, a large portion of those patients eligible for anti-IgE therapy was only eligible for omalizumab (35 out of 60 patients) and 42% of patients eligible for omalizumab were also eligible for mepolizumab but fewer patients who were eligible for omalizumab were also eligible for reslizumab, which is comparable to the IDEAL study. Our study adds information to the previous literature since the IDEAL study did not assess eligibility for benralizumab. Within the anti-IL5 therapies, due to the difference in the eosinophil cutoffs, it was interesting to note that all patients eligible for benralizumab were also eligible for another biologic, whereas this was not the case for mepolizumab or reslizumab, although the latter is not currently marketed in Brazil. The lack of overlap in eligibility suggests that careful consideration in the prescription of biologics is required and that patients and physicians would further benefit from different choices within the healthcare system. Conversely, the overlap between eligibility for different therapies seen in a subgroup of patients would suggest that some patients may benefit from one biologic even where they do not respond to another, which has been the case with biologic therapies in other diseases such as Rheumatoid arthritis ([27](#)).

One key finding of our study was the poor level of asthma control among SA patients despite the use of biologics. This finding is consistent with the results of a poor response to biologics in a cohort of patients with severe asthma who do not respond to conventional therapy. This finding has also been reported in other studies. Many patients may not truly have severe asthma, and some of these factors include (1) poor adherence (2,33), of which the latter has also been reported in SA, and (3) poor adherence. Uncontrolled asthma is an important factor for morbidity and mortality for most



exacerbations in the previous 12 months. This study showed a higher proportion of patient (78%) that had at least one asthma exacerbation in the previous year. Indeed, the literature also points to a high number of SA patients experiencing exacerbations in other cohorts, with 41% to 83% of SA patients reporting at least one exacerbation in the last year in these studies ([22-24,28,32](#)). Although the frequency reported varied among studies, probably because of methodological differences and definition of exacerbations, all studies report that these patients are experiencing a high frequency of exacerbations, highlighting what is still an unmet need for these patients.

Other factors that may influence asthma control are adherence to treatment and an adequate inhaler technique, which are crucial to deliver the right amount of drug to the lungs. Previous studies have described an association between the use of multiple inhalers or devices and non-consented switches of inhalers, with higher rates of non-adherence ([35,36](#)). Most of the ERS/ATS 2014 SA patients (>80%) in our study used at least two different inhalers (one device for the ICS and another for the ICS plus LABA), bringing complexity to the therapeutic approach, potentially affecting treatment adherence and, ultimately, asthma control.

Our study has some limitations. Most of these data, including exacerbations, were self-reported by the patient and thus may be subject to recall bias. However, the higher prevalence of some comorbidities (e.g. hypertension and GERD) and higher frequency

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with SA are eligible for add-on biological therapies, but none of them had access to this form of treatment in our cohort. Almost half of them were not eligible to any of the approved biologics, however. Eligibility for biologics needs to be carefully considered as some patients may only be eligible for one type of anti-IL5 therapy or for anti-IgE therapy exclusively. Conversely, overlap between biological therapy eligibility would suggest where patients do not respond to one therapy, they may benefit from trial of another therapy although further research needs to be carried out in this regard. Overall, this emphasizes the need for a more personalized approach, targeting better disease outcomes and improved quality of life for the patient. While there is a need to increase access for some of those eligible that may really need a biologic treatment, continuous efforts are required to develop alternatives to those who are not eligible to approved options.

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Data availability

To request access to patient-level data and documents for this study, please submit an enquiry via www.clinicalstudydatarequest.com.

Additional information

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