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(866) 423-7849

Factoring Comorbidities into Treatment Plans for Patients with Eosinophilic Asthma

Announcer Introduction

You're listening to *Clinicians Roundtable* on ReachMD, and this episode is sponsored by GlaxoSmithKline. Here's your host, Dr. Jennifer Caudle.

Dr. Caudle:

Welcome to *Clinicians Roundtable* on ReachMD. I'm your host Dr. Jennifer Caudle, and joining me to discuss how we can factor comorbidities into treatment plans for patients with eosinophilic asthma are Drs. Ian Pavord and Praveen Akuthota.

Dr. Pavord is a Professor of Respiratory Medicine in the Nuffield Department of Medicine at the University of Oxford. Dr. Pavord, welcome to the program.

Dr. Pavord:

Thank you very much. I'm delighted to be here.

Dr. Caudle:

And Dr. Praveen Akuthota is a pulmonary and critical care physician and Associate Professor of Medicine at UC San Diego Health. Dr. Akuthota, welcome to the program.

Dr. Akuthota:

Thanks for having me.

Dr. Caudle:

Alrighty, so let's dive right in. So starting with you, Dr. Akuthota, can you tell us about some of the common comorbidities that are associated with eosinophilic asthma.

Dr. Akuthota:

Yeah. Thanks, Dr. Caudle. Eosinophilic asthma exists often within a spectrum of potential comorbidities. The one that I would most commonly point to is allergic rhinitis sinusitis, which very commonly is associated with eosinophilic asthma and itself has some eosinophilic pathology associated with it. And allergic rhinosinusitis can be with or without nasal polyps. The other comorbidities that I would point to as potentially common co-travelers with eosinophilic asthma are atopic dermatitis, particularly in children, perhaps less so in adults. We're learning more and more that eosinophilic gastrointestinal disease, eosinophilic esophagitis in particular, can be associated with eosinophilic asthma as well.

And then finally, I'd like to also mention that eosinophilic asthma can sometimes be part of a more systemic eosinophilic disease, and clinicians should be mindful that eosinophilic asthma that is associated with very high-grade eosinophilia may indeed be something systemic like eosinophilic granulomatosis with polyangiitis or EGPA, may be actually chronic eosinophilic pneumonia, or other entities like allergic bronchopulmonary aspergillosis.

So that would be my summary of the spectrum of potential comorbidities or co-travelers with eosinophilic asthma.

Dr. Caudle:

And as a quick follow-up to that, Dr. Akuthota, are there overlapping symptoms between those comorbidities and eosinophilic asthma?

Dr. Akuthota:

Yeah, that's a great question, Dr. Caudle. With some of these conditions that are in very different organs like eosinophilic GI disease or atopic dermatitis, you don't tend to see a great deal of symptomatic overlap. But with allergic rhinosinusitis, there certainly can be symptom overlap. Patients who have increases in upper airway symptoms can often associate with increases in lower airway symptoms as well and vice versa. And treating the allergic upper airway disease can often be a very key component of asthma control. So there can be some significant overlap when we think about the connection between the upper and lower airway.

Dr. Caudle:

Excellent. And with all that in mind, let's turn to you now, Dr. Pavord. How do the comorbidities and symptoms that Dr. Akuthota discussed factor into your treatment plans?

Dr. Pavord:

Well first of all, assessment; I think it is very important to recognize what the symptoms are due to. And it can be difficult with upper airway disease in particular because it can produce symptoms that are confused with those due to asthma. So careful assessment. And it's always important to ask about upper airway disease in a patient with asthma, and particularly severe eosinophilic asthma. Maybe 60% of patients will have chronic rhinosinusitis and nasal polyposis.

In terms of treatment, the biologic treatment can have a very big impact in eosinophilic asthma. And we have a range of different biologic treatments targeting different aspects of the type 2 immune response. And they all have some efficacy against type 2 comorbidities.

Dr. Caudle:

Excellent. And for those of you who are just tuning in, you're listening to *Clinicians Roundtable* on ReachMD. I'm your host, Dr. Jennifer Caudle, and I'm speaking with Drs. Ian Pavord and Praveen Akuthota about treatment plans for patients with eosinophilic asthma.

Now, Dr. Pavord, clearly a patient's comorbidities play an important role in creating a treatment plan. But what about their goals and preferences? How do you factor them into your approach?

Dr. Pavord:

Well, the patient with comorbidities wants you to address all of the issues. And quite often, with eosinophilic comorbidities, there's a common solution. For example, oral corticosteroids are very effective for most eosinophilic disease. But patients really do worry for good reason about the use of oral corticosteroids. They get morbidity linked to the treatment itself. So they're looking for a joined effort approach, and they're also looking for a future where exposure to all corticosteroids is minimized.

And we are lucky to have biologic agents which are active against eosinophilic diseases in general that do offer the prospect of achieving control of these conditions without the need to resort to oral corticosteroids. So it's an exciting time.

But we as pulmonologists need to coordinate care to make sure it's holistic and that we're looking at the whole patient, not just their asthma, and make sure we bring in the relevant specialists in other areas: ENT, surgeons, rheumatologists, dermatologists, and coordinate that and ultimately deliver effective treatment which increasingly will be biologic treatment for these patients.

Dr. Caudle:

Excellent. And turning to you, Dr. Akuthota, can you share some other collaborative care tactics you use with your patients?

Dr. Akuthota:

Yeah, I think with eosinophilic asthma, as with many things, it takes a village, particularly when you're thinking about comorbidities. I have collaborators who are other clinicians and other specialties that I work with closely. In particular, my colleagues in allergy who not only take care of asthma, but take care of upper airways disease and other allergic conditions as well. I collaborate closely with rheumatologists as well, in case eosinophilic asthma is not just asthma but part of a systemic eosinophilic process like eosinophilic granulomatosis with polyangiitis. In that case, having a rheumatology colleague who I collaborate with is very important. Dermatologists, as well, for people who have associated dermatologic conditions, in particular, atopic dermatitis. Gastroenterologists for people who have associated GI disease, whether it be eosinophilic esophagitis or EGIDs, or eosinophilic gastrointestinal disease, that's below the esophagus as well. So my practice in particular focuses a little bit on eosinophilic disease. So even more so than just asthma in general. I intersect with all these specialties quite closely.

Dr. Caudle:

Excellent. And now before we close, I'd like to hear some key takeaways from each of you. Dr. Pavord, let's hear from you first.

Dr. Pavord:

These eosinophilic diseases often coexist. Of course, for the patient, what they want is a clinician that can recognize all of these conditions and consider them as part of one process and that the management that they apply will address as many of these issues as

possible. They're asking for a life that's free of oral corticosteroids, which was defective, for many of these eosinophilic conditions, extract quite a price in terms of side effects. And these side effects accumulate with time and become an important part of the clinical problem in many of our patients.

So increasingly, it's the pulmonologist I think that's getting most experience with biologic treatment that coordinates the care. And they need to assemble around them a number of allies: ear, nose, and throat, surgeons, allergists, and, rheumatologists with expertise in vasculitis. So that you can offer the patient sort of a multidisciplinary team approach to their problems.

Thank you, Dr. Pavord. And Dr. Akuthota, I'll give you the final word.

Dr. Akuthota:

Great. Thank you, Dr. Caudle. I would reiterate many of the things that Dr. Pavord had said, and in particular that in the current environment, the pulmonologist often sits at the center of these processes that surround eosinophilic asthma. So it's incumbent upon the pulmonologist to recognize these comorbidities, including upper airways disease in particular, but not just limited to that, to recognize that there may be associated systemic eosinophilic disease, that eosinophilic asthma may be a part of a larger process. And to also recognize other allergic comorbidities as well and to build that team of collaborators around them.

And then also to recognize that these comorbidities do dictate potential treatment plans, particularly in the era of biologics in which simultaneously treating eosinophilic asthma in conjunction with allergic upper airways disease may dictate the use of one particular biologic while the treatment of a systemic eosinophilic process may dictate the use of a different biologic.

So I think in this environment, the pulmonologist needs to think beyond the lungs and start thinking about other organs as well.

Dr. Caudle:

Those are some great takeaways for us to think on as we come to the end of today's program. I'd like to thank my guests, Drs. Ian Pavord and Praveen Akuthota, for joining me to share key considerations when creating treatment plans for patients with eosinophilic asthma. Dr. Pavord and Dr. Akuthota, it was great having you both on the program.

Dr. Akuthota:

Thank you.

Dr. Pavord:

Thank you very much.

Announcer Close

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