LETTERS TO THE EDITOR

On the Guidelines for the Diagnosis and Management of Difficult-to-Control Asthma

To the Editor: I would like to comment on several aspects of the recently published and magnificent "Guidelines for Difficult-to-Control Asthma,"[1] keeping in mind the difficulty of writing on a topic that has been one of the most complex in the specialty right from the beginning when we set to naming the disease. My first point, in fact, has to do with this semantic aspect; the other 3 points focus more on the article itself. The authors begin by claiming that *difficult-to-control asthma* is the best name for asthma that is symptomatic despite appropriate treatment and that they have chosen the name based on correct usage in Spanish. However, I believe that *refractory asthma* is the clearer term. *Refractory*, according to the *Diccionario del Español Actual*,[2] is that which is resistant or immune to something; in this case, asthma resistant to corticosteroids, a type of asthma that has been reported to affect approximately 5% of asthmatics. The phrase *difficult-to-control asthma* obliges the authors to define 2 groups: the false and the true, depending on the depth of the investigation, although in my opinion management guidelines for a disease should be based on the assumption that specialists know how to make a diagnosis, in this case of refractory asthma, once the differential diagnosis has been evaluated step by step including assessment of therapeutic compliance, concomitant conditions and aggravating factors. Specialists reach a conclusion by following a protocol in which the possibility of refractory asthma is considered. At the end of a process that is a bit like playing with a set of Russian matryoshka dolls, they can conclude that the asthma in question is refractory since the patient is symptomatic despite inhaled corticosteroids administered in doses as high as 3200 µg of inhaled budesonide (or 2000 µg according some authors[3]).

Once the specialist has ruled out the very rare asthma resistant to corticosteroids (occurring in from 1 in 1000 cases to 1 in 10 000), various possibilities remain that could explain why a patient's asthma is difficult to control. Two of them have to do with associated aggravating factors that are not explained in the aforementioned guidelines. One factor is the excessive use of β-adrenergic drugs, which have been demonstrated in vitro to interfere with glucocorticoid receptors, thus undermining the efficacy of corticosteroids. The other factor is tobacco use. Smoking has recently been defined as an independent predictor of poorly controlled asthma. Other factors may be perception of airway hyperresponsiveness, low socioeconomic status, and high doses of corticosteroids,[5] the efficacy of which is reduced in asthmatic smokers.[6]

Finally, I am somewhat confused as to why the authors adopt, albeit with modifications, the diagnostic criteria of the American Thoracic Society (ATS)[7] for refractory asthma when they establish such asthma as a diagnostic possibility based on the presence of only 2 major criteria (oral corticosteroids for more than 6 months per year or high doses of inhaled corticosteroids plus an additional medication, normally a long-acting β_2-agonist). In such cases the diagnosis of severe asthma (which requires high doses of corticosteroids) overlaps that of refractory asthma, which we have pointed out is assumed to be asthma that persists despite corticosteroid therapy. Then it would be the minor criteria —at least 2 of the 7 proposed by the ATS—that would to some extent explain the inability to control the disease and would distinguish, so to speak, between refractory asthma and severe asthma.

At any rate, together with these comments go my most sincere congratulations to the authors for their effort in compiling guidelines of such overall high quality for use in Spain, for such a complex disease. It stands to reason that, since these guidelines provide both an overview of the disease and detailed considerations, pneumologists who study them will learn to manage refractory or difficult-to-control asthma well, and therefore will manage other types of asthma with greater facility.

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