Dr. Ouellette receives honoraria for speaking from Ortho Biotech, Pfizer, and Boehringer Ingleheim. Reproduction of this article is prohibited without written permission from the American College of Chest Physicians (www.chestjournal.org/misc/reprints.shtml).

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From the Editor:

We thank Drs. Kahn and Goitein for their interest in reading the November 2005 Supplement to CHEST, entitled “Improving Outcomes in Respiratory Failure: Ventilation, Blood Use, and Anemia Management” and for taking the time to comment on it. Because the publication was supported by an educational grant from a pharmaceutical company, Drs. Kahn and Goitein have expressed concerns that the Journal “acquires a financial conflict of interest that casts doubt on its editorial independence” and “supplements such as these erode the confidence of the readers in the scientific objectivity of the editors.”

In preparing our response, we reread the Supplement in question from cover to cover. The series of articles that make up the Supplement are well written and fair and accurate reviews of the field, and they contain useful educational and patient management literature for our readers. While the reviews do not provide much primary data, review articles usually don’t. Nevertheless, references to the primary data have been provided by the authors. These articles were based on proceedings of a symposium that was held at the Annual Meeting of the American College of Chest Physicians (ACCP) on October 28, 2003, in Orlando, FL. The Scientific Program Committee selected and approved the speakers and their topics. The speakers were chosen because they are experts in the field. Each disclosed any potential conflicts for all to review. Before the Supplement was accepted for publication, each article and the entire Supplement were independently peer reviewed.

The ACCP and CHEST are cognizant of the potential concerns that Drs. Kahn and Goitein voice and have strict policies and firewalls in place to guard against them (www.chestjournal.org/misc/chest5.shtml, Editorial Guidelines and Price Schedule for Supplement Submissions; www.chestnet.org/education/program/jointSponsorship.php, ACCP Joint Sponsorship Fee Structure; www.chestnet.org/education/program/ccp.php, ACCP Continuing Education Policies). In brief, because an educational grant from industry was involved, the ACCP had to meet the guidelines of the Accreditation Council for Continuing Medical Education, specifically the 2004 updated standards of commercial support with attention to sections four and six. The ACCP also follows guidelines as outlined by the American Medical Association under their Council on Ethical and Judicial Affairs and their Physician’s Recognition Award and credit system. In accordance with these collective guidelines, grants for educational programs must be unrestricted and disclosed to the learner. Such was the case with this grant.

Without the unrestricted educational grant from Ortho Biotech, it would not have been possible to offer this symposium to our readers. Moreover, without unrestricted grants from industry, it would also not have been possible for the ACCP to have published other highly regarded supplements such as The Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy: Evidence-Based Guidelines, The Diagnosis and Management of Cough: ACCP Evidence-Based Clinical Practice Guidelines, The Diagnosis and Management of Pulmonary Arterial Hypertension: ACCP Evidence-Based Clinical Practice Guidelines, or the Diagnosis and Management of Lung Cancer: ACCP Evidence-Based Guidelines.

CHEST will continue to publish high-quality, peer-reviewed Supplements, even if they are supported by unrestricted educational grants from industry, because they are too important to our patients, our members, and our field, and because not all journals publish them, as Dr. Kahn and Goitein have pointed out. Nevertheless, we will remain ever vigilant to avoid the very important concerns of Drs. Kahn and Goitein because scientific objectivity and credibility are core values of this journal and the editorial board.

Richard S. Irwin, MD, FCCP, Editor-in-Chief, CHEST
Northbrook, IL

Dr. Irwin discloses that he has no real or potential personal or financial conflict of interest.

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Aerosol Delivery Devices

To the Editor:

The conclusions reached by Dolovich and colleagues in a special report of meta-analyses of randomized controlled clinical trials of aerosol delivery devices and inhaled therapy for patients with asthma and COPD are concise and show that devices used for the delivery of bronchodilators and steroids can be equally efficacious. However, we believe that when selecting a delivery device, much more prominence should be given to a patient’s ability to use the selected device correctly. The conclusion that all devices can be equally efficacious was obviously obtained from analyses of randomized controlled clinical trials in which patient participation required the ability of patients to use the devices being studied correctly. That there were no differences in drug efficacy between different delivery systems is therefore expected.
There is now clear evidence that misuse of corticosteroid metered-dose inhalers is associated with decreased asthma control, and previous studies have reported a decreased bronchodilator response in patients not using the pressurized metered-dose inhaler correctly. Incorrect use of inhalation devices has been reported frequently in the past; in the literature search reported by Cochrane et al, the frequency of efficient inhalation technique ranged from 46 to 59%. These findings support our view that the most important recommendation to clinicians about the prescription of an inhaler is the confirmation by observation that the device can be used efficiently. The conclusions of the meta-analyses reported by Dolovich et al do not emphasize the importance of checking inhaler technique in all patients prior to the prescription of any inhalation device for the first time, and the need to check technique regularly thereafter especially if there is poor symptom control.

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REFERENCES

To the Editor:

Teaching patients correct inhaler technique and reinforcing this technique with each subsequent office visit are indeed key steps to the successful implementation of aerosol therapy, as aptly stated by Drs. Barnes and Crompton. In 1982, Crompton identified the difficulties patients had when using their metered-dose inhalers; and this article, along with eight others, were discussed in the introduction to our meta-analysis. In addition, the take-home message from the meta-analysis was that for patients unable to master the required inhalation technique for a specific delivery device, other choices for inhalers delivering equivalent drug doses and providing the same clinical efficacy were often available. The importance of correct inhaler technique to successful therapy was stressed throughout the body of the text, with the points made in the Abstract re-emphasized in the concluding paragraphs, in which we restated that competence in the use of an inhaler needed to be confirmed by the physician or health-care worker when choosing an aerosol delivery device for their patient.

The selection criteria for studies included in the meta-analysis were randomized controlled trials (RCTs) in which responses to the same drug were tested using different delivery devices, thus eliminating the influence of device/drug combinations. In the descriptions of the methods and subject inclusion criteria for the many studies we reviewed, patient ability to use the various devices was one of the variables frequently mentioned. One can only assume that an inability to use a device correctly excluded a subject from a trial, but also that correct inhaler technique was taught prior to study entry. The studies selected for analysis included trials in which devices were tested under conditions of actual clinical use (type 1 studies) or in a laboratory setting with well-trained subjects (type 2 studies). In the former, inhaler technique may have been reinforced on clinic visits but not monitored otherwise. Barnes and Crompton have stated that the use of correct inhaler technique in all studies analyzed resulted in our not discerning differences in efficacy between devices, and this may be true. However, the purpose of the meta-analysis was to test whether device performance influenced response, independent of drug, and with patients able to use the devices correctly. β2-Agonists were the test drugs for the majority of the RCTs, with doses sufficient to achieve the plateau of the dose-response curve. Only four studies of corticosteroids met the selection criteria for inclusion in the analysis; these RCTs compared metered-dose inhaler plus spacer to dry powder inhaler use in well-controlled adult asthmatics and showed no differences in response using either delivery device. It is possible that these results were only a consequence of patients using the correct inhaler technique. We do agree that poor inhaler technique is a contributing factor to loss of asthma control and would welcome RCTs comparing delivery devices in this population. We fully agree with Drs. Barnes and Crompton that a patient’s ability to use an aerosol delivery device correctly is an exceedingly important aspect when choosing an inhaler, and thank them for underscoring this point in their review of the guidelines.

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Mometasone and Beclomethasone Comparison Article Observations

To the Editor:

Chrousos et al (July 2005) cited an article by this letter’s coauthor stating that “…as dry powder inhaler delivery of ICS