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Bronhijalna astma teška za lečenje, teška astma i primena biološke terapije

Bronchial Asthma Difficult to Treat, Severe Asthma and Biological Therapy Use

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Apstrakt

Svedoci smo razvoja bolesti astme. Evolucija dijagnoze astme išla je od jedne jedinstvene bolesti do činjenice da je to kompleksna, heterogena bolest sa mnogobrojnim fenotipovima i endotipovima. Kroz istoriju, astmu smo sagledavali i klasifikovali na različite načine. Prva fenotipizacija odnosila se na ekstrinzik i intrinzik astmu, devedesetih godina javili su se klasteri sa ranim i kasnim početkom, pa sve do današnjih dana kada, na osnovu inflamacije u disajnim putevima, govorimo o Th2 high i Th2 low astmi (T2 i non T2 astmi). Klasifikacija astme išla je od kliničke do biloški fokusirane.

Paralelno sa razvojem definicije, dijagnoze i klasifikacije, evoluirala je i terapija. Pristup lečenju išao je od klasičnog, standardnog stepeničastog pristupa istog za sve, do personalizovanog, gde će se terapija davati pravom pacijentu u pravo vreme, pravi lek za pravu dijagnozu. Terapija će biti preventivna, prediktivna, personalizovana i participativna.

Po GINA smernicama bronhijalnu astmu lečimo na osnovu težine, i to u 5 koraka. Dijagnoza je retrospektivna, tj. bazirana je na tome kojom terapijom možemo postići i održati kontrolu simptoma astme, kao i smanjiti rizik od pogoršanja. Astma teška za lečenje može se susresti na svakom koraku lečenja, teška astma je prisutna samo na koraku 4 i 5.

U osnovi astme teške za lečenje i teške astme je nekontrolisana astma. Astma teška za lečenje je svaka nekontrolisana astma koja se javlja i pored primene sve preporučene terapije na koraku 4 ili 5. Ako smo ispoštovali terapijske modalitete, proverili tehniku inhalacije, adherencu, komorbiditete, faktore rizika, izvršili optimizaciju lečenja i ako i posle 3 meseca imamo nekontrolisanu astmu, onda možemo pričati o teškoj astmi. U tom slučaju pristupa se fenotipizaciji, na osnovu inflamacije u disajnim putevima, kada se određuju biomarkeri (br. eozinofila u perifernoj krvi, ukupni i specifični IgE, FeNo ...) i ukoliko se ispune kriterijumi, pristupa se aplikaciji biološke terapije (monoklonska antitela). Za sada je u našoj zemlji dostupna terapija za T2 inflamaciju u disajnim putevima (anti IgE – omalizumab, anti Il5 – reslizumab, i anti IL5 receptor – benralizumab). Rezultati primene ove vrste terapije gotovo da prevazilaze očekivanja u pogledu poboljšanja, simptoma, kvaliteta života, plućne funkcije, smanjanja egzacirbacija, korišćenja sistemskih KS.

Abstract

We are witnessing the development of asthma as a disease as a whole. The evolution of the diagnosis went from a single disease to the present day when we know that it is a complex, heterogeneous disease with numerous phenotypes and endotypes. Throughout history, asthma has been viewed and classified in different ways. The first phenotyping was related to extrinsic and intrinsic asthma, early and late-onset clusters in the 1990s, until today when, based on inflammation in the airways, we speak of Th2 high and Th2 low asthma (T2 and non-T2 asthma). Classification of asthma ranged from clinical to biologically focused.

In parallel with the development of definition, diagnosis, and classification, therapy has also evolved. The approach to treatment went from the classic, standard step-by-step approach, the same for everyone, to a personalized one where we will give therapy to the right patient in the right way, the right medicine for the right diagnosis. The therapy will be preventive, predictive, personalized, and participatory.

According to GINA guidelines, we treat bronchial asthma based on severity in 5 steps. The diagnosis is retrospective, i.e. based on which therapy we can achieve and maintain control of asthma symptoms, as well as reduce the risk of exacerbation. "Difficult to treat asthma" can be encountered at every treatment step, and "severe asthma" is only present at steps 4 and 5.

At the root of difficult-to-treat and severe asthma is uncontrolled asthma. Asthma that is difficult to treat is any uncontrolled asthma despite the application of all recommended therapy at steps 4 or 5. If we followed the therapeutic modalities, checked the inhalation technique, adherence, comorbidities, and risk factors, and optimized the treatment, and if we still have uncontrolled asthma after 3 months, then we can talk about severe asthma. In that case, phenotyping is approached on the basis of inflammation in the respiratory tract when biomarkers are determined (number of eosinophils in peripheral blood, total and specific IgE, FeNo...) and if they meet the criteria of access to the application of biological therapy (monoclonal antibodies). For the time being, therapy for T2 inflammation in the respiratory tract is available in our country (anti-IgE - Omalizumab, anti-Il5 - Reslizumab, and anti IL5 receptor - Benralizumab). The results of applying this type of therapy almost exceed expectations in terms of improvement,symptoms, quality of life, lung function, reduction of exacerbations, use of systemic skeletal system.

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