Editorial

Pros and Cons of Endoscopic Treatment of Emphysema

Luces y sombras del tratamiento endoscópico del enfisema

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Pros and Cons of Endoscopic Treatment of Severe Asthma

For a long time now, pulmonologists have been searching for a minimally-invasive alternative to lung volume reduction surgery, especially since the NETT study demonstrated that the surgical technique improves the functional capacity and quality of life of some patients with severe emphysema.1 What is most striking of the NETT study is that a subgroup of patients with emphysema, predominantly in the upper lobes and with poor tolerance to effort, reached an unprecedented increase in survival. As strange as it may seem, it was that same assay that led to the demise of the NETT study. In the United States when evidence was given of the high price that some patients had to pay for improvement (5.5% mortality and morbidity higher than 50%), including a notable increase in mortality of some high-risk subgroups.2 Currently, and despite the positive results of NETT, less than 200 surgical interventions are performed annually in the US.3 The paradoxical failure of the NETT study gave rise to a spectacular proliferation of medical mechanisms whose goal is to find a minimally-invasive alternative to surgery.

The pioneers of the endoscopic treatment of emphysema tried to reproduce the benefits of the NETT, avoiding the frequent complications of this therapeutic option, such as air leaks and prolonged hospitalizations. The initial postulated research hypothesis was aimed at achieving a clear improvement in respiratory functional tests, selecting patients with heterogeneous emphysema predominantly in the upper lobes. Later, the paradigm changed. Some opted to avoid lung volume reduction and center on redistribution, using computed tomography (CT) as a scale instead of the functional tests, selecting patients with heterogeneous emphysema (averaging 8 points in FEV1, 6-minute walk test (19 meters), and statistically significant, but not conclusive. Improvement was observed in FEV1 (60 ml), 6-minute walk test (19 meters), and favorable changes in the SGRQ with the treatment (average 3.4 points).9 Although these results can be considered hopeful due to their statistical significance, the number of hospitalizations due to COPD exacerbations was much greater in the treatment group (17 vs. 1) as was the incidence of hemoptysis. The fear of worsening things was greater than the hope deposited in these meek, favorable results.

The European study of the Spiration valves, smaller than the VENT study but controlled by placebo, has also been unable to demonstrate that endoscopic techniques represent a clear alternative to surgery. The patients treated in this study, in which two Spanish centers participated, presented an initial improvement of more than 4 points on the SGRQ combined with a significant reduction of the lung volume of the upper lobes. Curiously enough, the magnitude of the placebo effect was similar at three months, the time at which the patients of the control group received valves as required by the protocol and by logical medical ethics. At the end of the study, 31% of the patients treated experienced a decrease of 8 points on the SGRQ.

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and a significant reduction in the lung volume of the upper lobes treated. The parallel assay done in the United States will tone down the impact of the placebo effect as the randomization is prolonged for 6 months.

Those of us who continue to research the possibilities of endobronchial valves keep our hope up, as our aim is to find a minimally-invasive option over surgery. The most obvious advantages would be its low morbidity and mortality, but amongst the other advantages is its reversibility. The option of withdrawing valves from the airway in the event of complications is especially attractive, and in fact this was necessary in 20% of the patients in the Spiration pilot assay. Unfortunately, we still do not know whether we should concentrate on bilateral or unilateral treatment. We have no idea whether it is preferable to treat the most damaged lobe or if we should follow the path of the NETT and treat only patients with upper lobar emphysema. It is not clear how to avoid collateral ventilation in order to achieve a greater reduction in lung volume in those patients undergoing lobar exclusion (the Chartis® endobronchial ventilation in order to achieve a greater reduction in lung volume in upper lobar emphysema). It is not clear how to avoid collateral ventilation in order to achieve a greater reduction in lung volume in those patients undergoing lobar exclusion (the Chartis® endobronchial device was developed by Pulmonx for this goal). On the other hand, we are still searching for a scientific explanation to justify the improvement in the quality of life of subjects who experience no functional changes, improvement in gas exchange, or greater tolerance to effort. Nor is it clear whether the demonstrated changes in the SGRQ are sufficient enough for the treatment to be worth it. One of the great unknowns, and perhaps the most interesting observation of the randomized assays completed to date, is the magnitude of the placebo effect of bronchoscopy. This finding is in common with other endoscopic techniques, such as bronchial thermoplasty, and is a powerful impediment when interpreting questionnaires like the SGRQ in assays that are not controlled by placebo. Last of all, the high cost of the treatment, estimated at $12,000-$20,000 per patient, is worrisome.

Aside from the growing debate involving unidirectional valves, other techniques have emerged that rival these in scientific theory and are currently being studied. Among these are treatment with biological glue, lung volume reduction by thermal vapor and the placement of transbronchial prostheses to aide in the exhalation of trapped air. Bioglu and bronchi prostheses offer the possibility for treatment in patients with homogeneously-distributed emphysema. The former, developed by Aeris in the US, has yielded a polymer that concentrates on bilateral or unilateral treatment. We have no idea whether is preferable to treat the most damaged lobe or if we should follow the path of the NETT and treat only patients with upper lobar emphysema. It is not clear how to avoid collateral ventilation in order to achieve a greater reduction in lung volume in those patients undergoing lobar exclusion (the Chartis® endobronchial device was developed by Pulmonx for this goal). On the other hand, we are still searching for a scientific explanation to justify the improvement in the quality of life of subjects who experience no functional changes, improvement in gas exchange, or greater tolerance to effort. Nor is it clear whether the demonstrated changes in the SGRQ are sufficient enough for the treatment to be worth it. One of the great unknowns, and perhaps the most interesting observation of the randomized assays completed to date, is the magnitude of the placebo effect of bronchoscopy. This finding is in common with other endoscopic techniques, such as bronchial thermoplasty, and is a powerful impediment when interpreting questionnaires like the SGRQ in assays that are not controlled by placebo. Last of all, the high cost of the treatment, estimated at $12,000-$20,000 per patient, is worrisome.

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Prostheses have been studied in the randomized multi-center, placebo-controlled assay known as EASE. The results were presented in the European Congress in Barcelona this year. More than 300 patients were included from all over the world, and although an improvement in improvement in FEV1 could not be demonstrated, a significant reduction was reached in residual volume, with a mean of about half a liter. It once again became clear that endoscopic treatment of emphysema, homogenous in this case, results in an improvement in the quality of life of patients with severe emphysema. Unfortunately, the improvement was not lasting and, as was to be expected, more adverse effects were observed in the treatment group than in the control group.

For the moment, it is apparent that there is much left to be done. We know that the endoscopic treatment of emphysema allows for a limited reduction in regional or global lung volume depending on the technique used, and a significant improvement in quality of life in exchange for fewer morbidities and less mortality compared with surgery. The glass seems half empty when we compare the magnitude of the effect of endoscopic treatments with the benefits obtained with surgery, but half full when the comparison is with the pharmacological treatment of COPD. Improvements of 8 points on the SGRQ are not paltry when we compare this improvement with the changes of less than 4 points reported in emblematic studies such as TORCH or UPLIFT.

References

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