Transdermal Application of Steroid to Cervical Trachea for the Cough in Patients with Bronchial Asthma and Cough Variant Asthma-A Pilot Study

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Abstract

Background: The delivery of steroid to asthmatic patients has been limited to inhalation therapy or systemic therapy. The objective of this study was to evaluate the efficacy of transcutaneous application of steroid over the cervical trachea to asthmatic patients as an alternative route of drug delivery.

Methods: Five patients with bronchial asthma (BA), 10 patients with cough-variant asthma (CVA) and 13 patients with cough predominant asthma (CPA) whose symptoms were not adequately controlled despite their current therapy were enrolled in the study. Steroid ointment of mometasone furoate or betamethasone valerate, in the amount of 1/2 fingertip unit once or twice a day for up to 3 months, to the skin over the cervical trachea, was added to the current therapy. Diphenhydramine ointment was also tried by 14 of the study participants.

Results: Out of 28 patients receiving the steroid treatment, cough was reduced in 11 patients (39.3%). Cough disappeared completely in 3 cases, improved in 7 cases, and reduced temporarily but worsened again during the course in 1 case. Out of 14 patients receiving diphenhydramine treatment, cough was reduced in 5 patients (35.7%).

Conclusions: The existence of responders to topical steroid ointment therapy to the cervical trachea strongly suggests that the trachea is also involved as an airway inflammation site. Though less effective compared to inhaled corticosteroid therapy, the transdermal administration could be regarded as the third route of steroid therapy for asthmatic cough.

Keywords: Betamethasone valerate; Diphenhydramine; Mometasone furoate; Ointment; Tracheitis

Introduction

Inhaled corticosteroid (ICS) is currently regarded as the mainstay of asthma management and its introduction resulted in a decrease of asthma death [1]. However, complete resolution of the symptoms cannot always be achieved by medication, and oropharyngeal side effects such as hoarseness or stomatitis sometimes develop and result in under-control of the disease due to restriction of the inhalation dose [2,3]. Cough receptors are widely distributed in the airway including the trachea, and airway inflammation causes their hypersensitivity [4,5]. Not only the bronchus but also the trachea is regarded as an inflammatory site in asthmatic patients [6-8]. Since the trachea is in the lower respiratory tract where direct palpation over the skin is possible, we hypothesized that administration of a topical steroid through the skin could have some effects due to direct distribution of the drug to the tracheal surface for patients who have persistent coughing despite their current medications. We evaluated the efficacy of topical steroid application to the anterior cervix over the trachea in those patients whose cough symptoms were under-controlled with current therapies or because of their restricted use of ICS due to oropharyngeal side effects.

Material and Methods

The participants in this study consisted of bronchial asthma (BA), cough-variant asthma (CVA) or cough predominant asthma (CPA) patients whose symptoms were not adequately controlled by their current therapy including high-dose ICS, or due to restricted use of ICS due to oropharyngeal side effects such as hoarseness or stomatitis and who were treated at the Pulmonology Department of the National Hospital Organization Disaster Medical Center (Tokyo, Japan) between January 2006 and June 2007. CVA was defined as a continuous cough with minimal symptoms of wheezing [9]. CPA was defined as a chronic cough with minimal symptoms of wheezing [10]. Those who had dermal diseases at the site of application of the drug were excluded from the study.

Steroid ointment application to the skin over the cervical trachea was added to the current therapy. The area for application was above the upper edge of the sternum, between the right and left sternocleidomastoideus muscles, and below the cricoid cartilage (Figure 1). The amount of steroid ointment used was 1/2 FTU (fingertip unit), about 1 cm length derived from the tube, once or twice a day for up to 3 months. In some patients, diphenhydramine ointment was also tried. The steroid ointments used were mometasone furoate (Fulmeta® Ointment®, 0.1%, Shionogi, Osaka, Japan) and betamethasone valerate (Rinderon-V Ointment®, 0.12%, Shionogi, Osaka, Japan). Half FTU of the ointment contains around 150 μg of mometasone furoate or betamethasone valerate.

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transdermally delivered, at least in some patients, to the trachea, and suggests that tracheitis exists in patients with BA, CPA, and CVA when the patients have cough symptoms. Tracheitis may exist commonly in patients with diseases that cause coughing [6], and also Tanaka et al. demonstrated hypervascularity in both the trachea and bronchi of asthma patients by using high-magnification bronchovideoscopy [7], suggesting the coexistence of tracheitis and bronchitis. Cough receptors are distributed widely throughout the airways from the pharynx to the bronchi [4,5] and become hypersensitive when the nerve terminals are uncovered by loss of epithelial cells due to airway inflammation [4,5].

In non-steroidal anti-inflammatory drugs, direct drug delivery through the skin to the subcutis and underlying muscles [11,12] and to the synovial fluid [13,14] have been reported. Also, the subcutaneous tissue concentration of topically applied steroids under the application site is reported to be higher than the plasma concentration [15,16]. The extent of tissue penetration of topically applied drugs may differ among agents, possibly in relation to their lipophilicity and the conditions of ionization at local pH. In a rat model it was about 8 mm depth for lipophilic steroids (hydrocortisone, fluocinolone acetonide) [15] and 3-4 mm depth for non-steroidal anti-inflammatory drugs [16]. Also, in the rat model, a steroid prodrg (prednisolone sodium succinate) topically applied to the skin over the trachea caused a higher prednisolone concentration at the trachea than in plasma, and the use of iontophoresis resulted in a 12-fold higher prednisolone concentration at the trachea [17].

The time needed for symptoms improvement after topical application was rather fast ranging from minute to one hour. This might be explained by non-genomic effect of steroid that occurs with a rapid onset within minutes [18,19]. This effect is initiated by specific interactions with membrane-bound or cytoplasmic corticosteroid receptors, or nonspecific interactions with the cell membrane [20], and evidence suggests that the corticosteroid decrease airway blood flow by modulating sympathetic control of vascular tone, potentiating noradrenergic neurotransmission in the airway vasculature [21,22].

The effect of the ointment therapy does not seem to be universal, unlike inhaled corticosteroid therapy, but the existence of definite responders to the treatment suggested that topical steroid ointment therapy to the cervical trachea might be considered as a supplemental therapy choice. The factors influencing the efficacy may include differences in the drug permeability at the application site, differences in the inflammation sites in the airway, and differences in degree of inflammation, and should be investigated in a future study. We evaluated two kinds of steroid ointment in 7 cases, mometasone furoate (very strong) and betamethasone valerate (strong), and the effects evaluated two kinds of steroid ointment in 7 cases, mometasone furoate (very strong) and betamethasone valerate (strong), and the effects were almost equal except in one patient who reported mometasone predominance. Considering the possibility of side effects from long-term topical use, it might be better to choose betamethasone for this purpose.

In general, anti-histamines are not effective for treating BA, but in CVA and atopic cough, which are characterized by chronic bronchodilator-resistant non-productive cough with eosinophilic tracheobronchitis and cough hypersensitivity [23], they are reported to be effective [23,24]. Histamine promotes the release of ATP through H1 receptors and results in hypersensitivity of cough receptors [25]. Anti-histamine blocks this pathway and also inhibits the release of substance P from the C-fiber terminals [26]. In our experience, topical application of diphenhydramine ointment was also effective in a small number of patients and was thought to be effective for treating tracheitis through the above-mentioned mechanism.

The limitations of the study are as follows. The evaluation of the efficacy of the treatment was subjective and the number of patients recruited was small and not blinded, thus the placebo effect cannot be completely excluded. The optimum dose is not yet known and should be estimated in future. Adverse events from long time use of steroid ointment should also be taken into consideration.

**Conclusions**

Transdermal application of a steroid to the cervical trachea suppressed the cough in some BA, CPA, and CVA patients. This strongly suggests that the trachea is also involved as an airway inflammation site. The efficacy of the treatment seemed to be limited but the therapy can be considered as a supplementary therapeutic option when patients have with an itchy sensation over the anterior neck despite ICS treatment. The results of this pilot case-series study may suggest the necessity of the conduction of randomized placebo-controlled trial, and also additional use of iontophoresis might result in the improvement of the efficacy of the therapy and should be evaluated in a future study.

**References**


