Serum dehydroepiandrosterone sulfate concentration as an indicator of adrenocortical suppression during inhaled steroid therapy in adult asthmatic patients

Senja Kannisto, Anne Laatikainen, Antti Taivainen, Kari Savolainen, Hannu Tukiainen and Raimo Voutilainen

Departments of Pediatrics, Pulmonary Diseases and Clinical Chemistry, Kuopio University Hospital, Kuopio, Finland

(Correspondence should be addressed to R Voutilainen, Department of Pediatrics, Kuopio University Hospital, PO Box 1777, FIN-70211 Kuopio, Finland. Email: Raimo.Voutilainen@uku.fi)

Abstract

Objective: Supraphysiological doses of exogenous glucocorticosteroids cause adrenocortical suppression. Dehydroepiandrosterone sulfate (DHEA-S) is the most abundant adrenal androgen and estrogen precursor. We studied to what extent inhaled glucocorticosteroid therapy for asthma decreases serum DHEA-S concentrations.

Design and methods: We measured serum DHEA-S and cortisol concentrations in 101 adult patients with newly detected mild asthma before and after 2 and 12 weeks of treatment with inhaled glucocorticosteroids. The patients were randomized to receive budesonide 200 μg/day (low dose group, n = 50) or 800 μg/day (high dose group, n = 51) in two parallel groups double-blindly.

Results: In the low dose group, serum DHEA-S concentrations decreased from the baseline by a mean of 8% (95% confidence interval (CI), 3–13%, P < 0.01) after 2 weeks of therapy, and by 2% (95% CI, 9% decrease to 5% increase, NS) after 12 weeks. In the high dose group, the respective decreases were 16% (95% CI, 10–21%, P < 0.001) and 18% (95% CI, 12–24%, P < 0.001). The difference between the treatment groups was significant at both 2 and 12 weeks. During the 12 week treatment period the baseline concentrations of serum cortisol did not decrease in the low dose group, while in the high dose group the decrease was significant at 12 weeks (P < 0.01), but not at 2 weeks. The forced expiratory volume in 1 s improved equally well in both groups.

Conclusions: Inhaled budesonide decreased serum DHEA-S concentrations, which may indicate adrenocortical suppression. Reduced adrenal production of androgen and estrogen precursors may increase the risk of osteoporosis especially in postmenopausal women.

Introduction

Inhaled steroids have been advocated as the first line treatment in newly detected asthma (1). When considering the efficacy of the therapy, most experts recommend starting the treatment with high doses of inhaled steroids, and then to step down (2, 3). However, there are also reports showing that an equal clinical response is attained whether the treatment is started with a high or low dose (4). On the other hand, the risk of side effects, such as adrenocortical suppression and osteoporosis, increases when high doses are used (5–7). Serum dehydroepiandrosterone sulfate (DHEA-S) is quantitatively the most abundant steroid secreted by the adrenals. The vascular pool of DHEA-S is large, and it has a long (10–20 h) half-life. Thus the diurnal changes of serum DHEA-S concentrations are minor compared with those of cortisol. There is also evidence that adrenal androgen secretion is more sensitive than cortisol production to the suppressive effect of exogenous glucocorticosteroids (8, 9), and in postmenopausal women high doses of inhaled steroids suppressed serum DHEA-S levels (10). Likewise, in asthmatics admitted to hospital for severe bronchospasm, serum DHEA-S levels were decreased if the patients had used inhaled or oral steroids (11).

In the present study, we compared the changes in DHEA-S concentrations in patients starting either low or high dose inhaled steroid treatment. Our aim was to evaluate the applicability of serum DHEA-S measurements for monitoring systemic effects of inhaled steroids in adult asthmatic patients.

Subjects and methods

Subjects and medication

One hundred and one adult patients (18–68 years old) with newly diagnosed mild asthma were randomized into a parallel group, double-blind study (3). Patients
with severe asthma were excluded. None of the patients had received oral or inhaled glucocorticosteroids or other regular pharmacological treatment for their asthma before the study; only a short-acting inhaled β2-agonist or anticholinergic was allowed. All patients fulfilled the asthma criteria of the American Thoracic Society (12), and only patients with bronchial hyper-reactivity (PC20 of < 8 mg/ml, provocative concentration of histamine causing a 20% fall in forced expiratory volume in 1 s (FEV1)) were accepted into the study. The patients were randomized by a computer program to receive inhaled budesonide (BUD) either 200 µg/day (n = 50, low dose group) or 800 µg/day (n = 51, high dose group). BUD was administered with a dry powder inhaler (Pulmicort Turbuhaler; Astra Draco, Lund, Sweden) by using two types of inhalers: one containing a BUD 100 µg/dose and the other a 400 µg/dose. All patients took one inhalation twice daily. Signed informed consent was obtained from all patients. The study was approved by the Research Ethics Committee of Kuopio University Hospital.

Clinical and laboratory assessments

The patients were examined before any steroid treatment and after 2 and 12 weeks (3 months) of treatment. Airway obstruction was examined by measuring FEV1 by flow volume spirometry (Medikro 909 Spirometer; Medikro Ltd, Kuopio, Finland). The mean blood sampling time for serum cortisol and DHEA-S determinations was identical at all visits, at an average of 1000 h. The serum samples were stored at −20°C, and analyzed simultaneously. Serum DHEA-S was analyzed by a Coat-A-Count DHEA-SO4 RIA (Diagnostic Products, Los Angeles, CA, USA). The sensitivity of the assay was 0.03 nmol/l, and the intra-assay coefficient of variation was 3.8% for low and 5.3% for high values. The interassay coefficient of variation was 6.3 and 11% for low and high values respectively. Serum cortisol was analyzed by a Cortisol125I RIA Kit (Orion Diagnostica, Espoo, Finland). The sensitivity of the assay was 20 nmol/l, and the intra- and interassay coefficients of variation were 3.0 and 5.8% respectively, for the whole measuring range.

Statistical analyses

The data were analyzed by the Statistical Package for the Social Sciences, version 10 (SPSS, Inc., Chicago, IL, USA). For individual patients, the percentage changes of serum DHEA-S and cortisol values were calculated from the baseline (before treatment) values. The continuous variables were normally distributed (checked by using the histogram and Kolmogorov–Smirnov test). The statistical significance of the differences in the continuous variables was calculated using the t-test. Analysis of covariance was used for studying the effects of possible confounding factors between the treatment groups. P < 0.05 was considered statistically significant.

Results

At the beginning of the study, the groups did not differ in respect of age, sex, atopy, smoking, FEV1, or serum DHEA-S and cortisol concentrations (Table 1). There was no difference between the study groups in the use of inhaled β2-agonists or anticholinergics either at the start or during the study period. During the treatment, FEV1 improved significantly and equally well in both groups: mean change from 88.0 (% of predicted) to 89.7 in the low dose and from 86.7 to 88.3 in the high dose group. During the 3 month treatment period, the mean serum cortisol concentration did not change significantly in the low dose BUD group, while in the high dose BUD group it did (Fig. 1). In the low dose BUD group, the mean serum DHEA-S concentration decreased from the baseline by 8% (95% confidence interval (CI), 3–13%, P < 0.01) after 2 weeks, and by 2% (95% CI, 9% decrease to 5% increase, P = NS) after 3 months. The respective decreases in the high dose BUD group were 16% (95% CI, 10–21%, P < 0.001) and 18% (95% CI, 12–24%, P < 0.001) (Fig. 1). The mean percentage decrease in serum DHEA-S concentrations was significantly higher in the high dose than in the low dose BUD group at both 2 weeks and 3 months (P < 0.05 and P = 0.001 respectively), even when age or ventilatory obstruction (FEV1 value) was taken into account as confounding factors.

Discussion

Inhaled steroid therapy caused a significant decrease in serum DHEA-S concentrations. BUD 800 µg/day caused a constant decrease, while 200 µg/day caused only a mild and temporary decrease in the mean serum DHEA-S concentrations. These results suggest that in the long term the higher 800 µg/day dose has

Table 1 Characteristics of the patients at baseline. Values are expressed as means ± s.e.m. or mean (range).

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>BUD 200 µg (n = 50)</th>
<th>BUD 800 µg (n = 51)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex (male/female)</td>
<td>21/29</td>
<td>15/36</td>
</tr>
<tr>
<td>Age (years)</td>
<td>37.4 (18 – 68)</td>
<td>40.5 (19 – 62)</td>
</tr>
<tr>
<td>Smoking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>23</td>
<td>28</td>
</tr>
<tr>
<td>Ex-smoker</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>Smoker</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Atopy (yes/no)</td>
<td>32/18</td>
<td>36/15</td>
</tr>
<tr>
<td>FEV1 (% of predicted)</td>
<td>88.0±1.4</td>
<td>86.7±1.4</td>
</tr>
<tr>
<td>Serum cortisol (nmol/l)</td>
<td>299±18</td>
<td>279±18</td>
</tr>
<tr>
<td>DHEA-S (µmol/l)</td>
<td>5.9±0.43</td>
<td>5.6±0.53</td>
</tr>
</tbody>
</table>
systemic effects, while the lower 200 μg/day dose may be considered safe.

When starting the treatment of asthma, the same favorable clinical response can be obtained whether the dose of inhaled steroid is high or low (3, 4). Nevertheless, it has been suggested that quite high doses of inhaled steroids are needed to treat asthmatic inflammation and bronchial hyperresponsiveness (3, 13). However, after initial high dose treatment, the long-lasting control of asthma can be achieved by using quite low doses of inhaled steroids (14). Our data favor this kind of treatment policy, as the use of inappropriately high doses of inhaled steroids for a long time increases the risk of systemic side effects.

Some asthmatics, e.g. smokers, need high doses of inhaled steroids, and may therefore be at an increased risk of side effects (15). Some individuals, like perimenopausal women, may be exceptionally vulnerable to side effects (6). Therefore, a sensitive and simple screening test to identify systemic side effects is still needed. As was seen also in the present study, determination of serum cortisol levels in the morning is a rather insensitive way to assess adrenocortical suppression. For example, Ferguson et al. (16) did not detect any changes in baseline cortisol levels in children treated with inhaled BUD 800 μg/day or fluticasone propionate 400 μg/day. In the case of stimulation tests, a standard dose adrenocorticotropin (ACTH) test (250 μg) is insensitive in detecting mild adrenal suppression; up to 1000 μg/day BUD or beclomethasone did not affect the standard dose ACTH test results (17). A low dose ACTH test, in which ACTH is used at small doses (causing physiological ACTH concentrations), has been suggested to be more sensitive than the standard test to reveal adrenocortical suppression (5, 17), but this may not be true if appropriate test specific cut-off cortisol levels are used (18). However, in clinical practice these tests are also somewhat cumbersome, because they require repeated blood samples. We recently found out that there was a dose dependent decrease in serum DHEA-S concentrations in children during inhaled steroid therapy (9). In the present study the same phenomenon was seen in adult asthmatics, showing that serum DHEA-S measurement can be used as a screening method for detecting systemic effects of inhaled steroids; clearly low or decreasing serum DHEA-S concentrations during inhaled corticosteroid therapy suggest adrenocortical suppression. However, a more definitive test, for example an ACTH test, is needed to verify suppression of cortisol secretion. Thus serum DHEA-S measurement can be used to screen for adrenocortical insufficiency in glucocorticoid treated patients in the same way as recently reported in ACTH deficiency for organic reasons (19). It must be emphasized that there are situations where adrenal androgen production decreases while cortisol secretion is maintained or even elevated. This steroid pattern can be seen in chronic inflammatory diseases and chronic stress situations (20, 21).

In the present study, serum DHEA-S concentrations decreased within 2 weeks, while cortisol levels were suppressed significantly only after 12 weeks of high dose therapy. Thus adrenal androgen production was more sensitive than cortisol production to the suppressive effect of inhaled glucocorticosteroids. This finding is consistent with the studies of Cutler et al. (22) and Rittmaster and colleagues (8, 23), who found that adrenal androgen secretion is more sensitive than cortisol production to the suppressive effect of glucocorticoid therapy. One explanation for this may be that during exogenous glucocorticoid therapy the intra-adrenal steroid concentrations alter in a manner that favors cortisol compared with androgen production (22, 24).

What should we do if we accept and confirm that low serum DHEA-S concentrations in asthmatic patients indicate a systemic effect of inhaled glucocorticosteroids? If the disease is under good control, the steroid...
dose could be reduced or alternative treatment modalities could be considered. On the other hand, if the steroid dose cannot be reduced, DHEA treatment is a possibility to try to minimize at least some adverse effects of glucocorticosteroids (25).

In conclusion, serum DHEA-S concentrations decreased during inhaled steroid therapy. Clearly low or significantly decreasing serum DHEA-S concentrations during inhaled steroid therapy may indicate adrenocortical suppression and a risk of other systemic glucocorticoid side effects such as osteoporosis.

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References


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