from 2 to 30 Hz for the total respiratory system), $R_{Es}$ (resistance at 6 Hz) and $R_{Rs}$ (mean reactance).

The rank order of sensitivity or the discriminative power of the different physiologic tests to detect the effect of bronchodilation appeared to depend on the expression of the bronchodilator response. When relative percent changes were considered, $Raw$, $Rrs$, and $Rs$ were the most sensitive tests (but not $sGaw$), and when absolute changes were considered, FVC, $sGaw$ and $Raw$ were the most sensitive ones. Yet the best discriminating power was not reached by a single variable but by a pair of tests i.e. the greatest roots were obtained by FVC with a resistance parameter ($Raw$, $Rrs$, $Rs$, or $sGaw$) or by 2 resistance parameters (i.e. $Raw$-and $Rs$) or by FVC with $MEF_{25}$. For a comparison also the results of a histamine challenge in a group of asthmatics with normal baseline value were analysed [2] (table 2, upper panel), which gave similar results of thresholds, relative changes and rank order of sensitivity. The multiple variable analysis, furthermore, showed that the influence of histamine could be described completely by the relative changes of any one of the following variables: $FEV_1$, $sGaw$, $Rrs$ or $Rs$ (and that there was no advantage in using pairs of tests in this group).

For clinical practical purposes, spirometry and resistance measurements thus appear to be almost interchangeable and to have very comparable sensitivities. Yet it should be reminded that they have different thresholds.

**References**


**The assessment of reversibility; what drugs?**

R. Dahl*, C-G. Löfdahl**

In obstructive lung disease, it is common to test the influence of drugs on lung function parameters and to take the response in consideration for diagnostic classification of the disease. A number of pharmacological agents have bronchodilator activity when presented to the bronchial tissue from the luminal side when inhaled and from the blood vessels when given systemically by the oral or i.v. route.

**Beta-adrenergic agonists**

After oral intake of plain tablets, the maximum increase in forced expiratory volume ($FEV_1$) is seen after 1.5-2 h and a highly significant correlation has been found between the percentage increase in $FEV_1$ and serum concentration of terbutaline. After i.v., i.m., or s.c. administration the onset of action is seen within a few minutes and the maximum bronchodilation seen after 30-60 min.

**Methylxanthines**

Methylxanthines are widely used as bronchodilators in the treatment of obstructive lung diseases. The drug does not seem to reveal a reversibility in airways
obstruction not uncovered by a test with inhaled beta-adrenergic agonists, although one study has pointed to individual differences in the dose-response to oral theophylline and beta-2-agonist (terbutaline).

**Anticholinergic drugs**

In obstructive lung disease, inhaled ipratropium and oxitropium gives a bronchodilation. When tested in patients in "stable" condition the maximum effect is seen from 40 mg ipratropium. In allergic bronchial asthma, the bronchodilation from inhaled anticholinergic drugs seem inferior to the effect from an inhaled beta-agonist but in older, non-atopic patients the bronchodilations from an anticholinergic have been found equal or superior to inhaled beta-agonists.

**Oral antihistamines**

Antihistamines can improve resting lung function in a dose dependent manner. This effect has not been used systematically as a test for reversible airways obstruction.

**Corticosteroids**

Oral and inhaled corticosteroids may in some patients with airway obstruction improve dynamic and static lung volumes 3-9 h after dosing and it has been possible to show that this effect is dose dependent. This has been called the acute effect of corticosteroid.

Several days of corticosteroid treatment may be necessary to achieve an improvement in lung function as the effect is slow in onset and also longer lasting than the action of bronchodilators. Most patients respond during the first week of treatment. No correlation seem to exist between the immediate responsiveness to an inhaled beta-2-adrenergic agonist and the response to corticosteroids.

Bronchodilation can be achieved from drugs with different mechanism of action. The underlying disease mechanism may determine the responsiveness to the pharmacological agent applied. Several drugs often have to be tested to determine their role in a patient and as the acute response to a bronchodilator does not exactly predict a therapeutic response in long term treatment the clinical benefit from a treatment should always be determined. The response to single doses of a bronchodilator does not seem to define disease entities but simple shows the ability of the substance to influence airway calibre at that particular moment.

**The assessment of reversibility: short-term**

**R. Wettengel**

The objectives for short-term assessments are to prove the efficacy of drugs:
- in acute stages, e.g. acute severe asthma,
- after short-term application, mainly after a single dose or a few applications and repeated measurements of the parameters of airways obstruction within some hours,
- in an acute model.

For the clinician most important information comes from the comparison of pharmacodynamic effects of different drugs. For such purposes the differences between baseline values at different days and the minimal improvement, which has to be achieved with a standard drug has to be defined prospectively, e.g. $R_i \geq 25\%$, $\text{FEV}_i \geq 15\%$.

In an acute trial the efficacy may be described as follows:
- onset of action,
- maximum efficacy,
- duration of the plateau,
- duration of a clinical relevant effect, e.g. $\text{FEV}_i \geq 15\%$.
- $\text{AUEC}_{\text{line}}$ Which may be defined as $\text{FEV}_i \geq 15\%$.

There are many different questions to be proved in an acute trial:
- single dose studies of different drugs,
- different doses of one drug (dose-finding-study),
- cumulative dose of one drug to find out the maximum efficacy,
- repeated doses of one drug in different time intervals to compare the different formulations, e.g. for theophylline preparations.

Looking at the bronchospasmyotic effect of a new compound we obtain information which is clinically relevant; this does not apply to the provocation test model. Nevertheless such tests are often used because this model can nicely be standardized.

It may be applied in different modifications:
- the protective effect of different doses of one drug or of different drugs to a constant stimulus is compared,
- threshold doses are evaluated.

The test may be performed after a single application (when the efficacy is expected to be maximum) or under steady state conditions.

The assessment of drugs is mainly concerned with their protective effect but the challenge may be used to look at the reversibility of bronchoconstriction induced by different stimuli such as allergens, mediators, drugs, exercise, cold air or $\text{SO}_2$.

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