

COMPLAINANT v CHIESI

Allegations about promotional claims for Fostair and Trimbow

CASE SUMMARY

This case was in relation to a promotional video hosted on a Chiesi website that was allegedly misleading, incapable of substantiation and disparaging to competitor products. The claims at issue were *“Some conventional DPIs and pMDIs release particles too large to target the small airways”* and *“With Chiesi’s extrafine particles you can reach and treat the small airways”*.

The outcome under the 2024 Code was:

No Breach of Clause 2	Requirement that activities or materials must not bring discredit upon, or reduce confidence in, the pharmaceutical industry
No Breach of Clause 5.1	Requirement to maintain high standards at all times
No Breach of Clause 6.1	Requirement that information/claims/comparisons must not be misleading
No Breach of Clause 6.2	Requirement that information/claims/comparisons must be capable of substantiation
No Breach of Clause 6.6	Requirement that another company’s medicines must not be disparaged

**This summary is not intended to be read in isolation.
For full details, please see the full case report below.**

FULL CASE REPORT

A complaint was received about Chiesi Limited from a contactable complainant who described themselves as a health professional.

COMPLAINT

The complaint wording is reproduced below with some typographical errors corrected:

“This complaint refers to the following UK website content promoting extrafine products Fostair and Trimbow [URL provided] {reference number UK-RES-2501920} This extrafine formulation page consists of several promotional claims which link the 'formulation' and 'particles' of both products to make misleading superior efficacy and enhanced clinical outcome claims. The subject of this complaint focuses on the video on this page which is directly positioned under 'a hidden risk' banner. The video reference coding is {UK-RES-2502043}. The video displayed length is 1 minute 54

seconds in total duration. The issues with the video are the following

1. Timestamp 57 seconds to 1 minute 2 seconds claims that some conventional DPIs and PMDI release particles too large to target the small airways. This text is provided in capital letters to draw attention of the viewer and is a comparative claim of other inhaler products vs Fostair and Trimbow in the context of the video of small airways disease leading to reduced quality of life and other negative clinical outcomes. This specific claim is disparaging to several currently licensed inhalers available for treatment of asthma and COPD as many inhalers currently available have particle sizes that do sufficiently target both large and small airways. There is no qualification in the video around the claim of precisely which conventional inhalers release large particle size which adequately does not treat small airways. This disparaging, non-objective, unfair claim breaches clauses 6.1, 6.2 and 6.6
2. Timestamp 1:08 to 1:11 claims that With Chiesi's extrafine particles you can reach and treat the small airways. There is no robust clinical evidence to show that Trimbow and Fostair's extrafine particles provide a clinical benefit (treat small airways) or that they provide a clinical benefit (treat small airways) compared with other licensed treatments. Chiesi have not conducted any direct studies or head to head studies to demonstrate clinical superiority in favour of their extrafine particles/formulations or over other clinically appropriate comparators in treating small airways. Making such claims in the video directly linking extrafine particles to treating small airways is both misleading and incapable of substantiation. This claim within the video is a breach of clause 6.1, 6.2, 5.1 and 2.
3. The video overall is not appropriate as extrafine formulations/extrafine particle size merely refer to the dosing considerations of using Fostair and Trimbow compared to non-extra fine formulations which is discussed in both product summary of product characteristics documents. Chiesi have extrapolated the product formulation/particles dosing particulars to falsely and incorrectly claim that there is a superior benefit clinically to using Trimbow and Fostair and treating small airways via Trimbow and Fostair extrafine particles when Chiesi do not have data to support such a clinical advantage. Chiesi need to conduct studies which demonstrate that the extrafine formulation/particles directly links to a clinical benefit before making such claims. Overall the video breaches high standards and risks patient safety considering extrafine formulation and extrafine particle is merely a dosing requirement and is only a weak hypothesis for a clinical benefit as presented in this video- clause 5.1 and clause 2.”

When writing to Chiesi, the PMCPA asked it to consider the requirements of Clauses 2, 5.1, 6.1, 6.2 and 6.6 of the 2024 Code.

CHIESI’S RESPONSE

The response from Chiesi is reproduced below:

“We write in response to your letter of 9 December 2025 concerning a complaint about content on the healthcare professional section of Chiesi’s Chiesi Air website.

We take alleged breaches of the ABPI Code of Practice (the Code) extremely seriously. Chiesi is committed to maintaining the highest standards of scientific accuracy, integrity and compliance across all our activities, and we welcome the opportunity to respond transparently. On that basis, we have set out below our position

in relation to the complaint and the alleged breaches of Clauses 2, 5.1, 6.1, 6.2 and 6.6.

1. The Complaint

The complainant, a contactable healthcare professional, raises objections to claims on the 'extrafine formulation' page on the Chiesi Air website:

[URL provided] (UK-RES-2501920, the Webpage),

with particular focus on an embedded promotional video for Trimbow and Fostair:

[URL provided] (UK-RES-2502043, the Video).

From timestamp 00:57 to 01:02 the Video states '*some conventional DPIs and pMDIs release particles too large to target the small airways*.' The complainant notes this text is in capital letters, alleging that its intention is to draw the attention of the viewer. The complainant goes on to characterise the claim as a disparaging, comparative, non-objective and unfair claim and is incapable of substantiation (Clauses 6.1, 6.2, 6.6).

From timestamp 01:08 to 01:11 the Video claims '*With Chiesi's extrafine particles you can reach and treat the small airways*'. The complainant alleges this claim is misleading and not supported by robust clinical evidence (Clauses 6.1, 6.2, 5.1, 2).

The complainant goes on to say that the video '*overall is not appropriate*,' stating that Chiesi has extrapolated formulation characteristics to imply a superior clinical benefit without adequate support, and that the video breaches high standards and risks patient safety (Clauses 5.1 and 2).

Chiesi firmly refutes each allegation and respectfully submits that no breach of Clauses 2, 5.1, 6.1, 6.2 or 6.6 has occurred. Chiesi's full position in relation to each of the allegations is below at section 0.

2. PMCPA request for documentation and signatory details

- [list of documentation provided]

The following signatories were involved with the approval of the Webpage and the Video:

[signatory details provided]

3. Details of the Webpage, the Video and their intended audience

The Webpage and the Video are promotional content for Chiesi products, Fostair and Trimbow. Both are housed on the Chiesi Air Website, which is a healthcare professional-facing page. To access the Webpage and the Video a user must self-certify that they are a UK healthcare professional. A disclaimer of '*For UK healthcare professionals only*' is also displayed at the top of the Webpage banner.

4. Response to the Allegations

a. Complaint regarding the claim ‘some conventional DPIs and pMDIs release particles too large to target the small airways’

Chiesi firmly rejects the allegation that the claim ‘some conventional DPIs and pMDIs release particles too large to target the small airways’ is comparative or disparaging. The statement is a scientifically established fact, taken directly from the referenced source (Hasan *et al* 2021), and does not directly or indirectly refer to any competitor product or device.

i. Scientific context:

Particle size

It is widely recognised that particle size is a critical determinant of the deposition of inhaled medicines within the respiratory tract. Larger particles predominantly deposit in the oropharynx, including the central lung region (i.e. the upper bronchial tree), whereas smaller particles able to reach the peripheral lung regions (i.e. the small airways) (Usmani *et al* 2021).

Inhaled medicines generate an aerosol containing a distribution of particle sizes. The mass median aerodynamic diameter (MMAD) is used to characterise this particle distribution (Jabbal 2017). Although all inhalers emit a range of particle sizes, it is the MMAD that determines whether a formulation is considered to have an ‘extrafine’ particle size. The MMAD means that 50% of particles in the aerodynamic size distribution, based on mass, lie above and below that diameter (Muralidharan 2015).

The Global Initiative for Chronic Obstructive Lung Disease 2026 Report (GOLD 2026) reinforces the importance of particle size in determining deposition patterns:

‘Particles > 5 µm are most likely to be deposited in the oropharynx. For drug delivery to the lower respiratory tract and lungs, particle size (mass-median aerodynamic diameter) can be fine (2-5 µm) or extra-fine (< 2 µm), which influences the total respirable fraction (particles < 5 µm) and the amount and site of drug deposition (more peripheral deposition with extra-fine particles)’ (GOLD 2026).

Extrafine particles and their relevance

Furthermore, inhalers with an extrafine formulation have demonstrated optimised delivery to lung regions and particularly to the small airways (Usmani *et al* 2021). It is an accepted principle that formulations with a smaller MMAD have been shown to provide higher lung deposition with better penetration into the small airways than those with a higher MMAD (Corradi *et al* 2014).

Lung imaging deposition indices

The International Society of Aerosol in Medicine (ISAM) the world's leading inhalation science and aerosol medicine society, published a reference document '**Standardization of techniques for using planar (2D) imaging for aerosol deposition assessment of orally inhaled products**'. This document identified the central to peripheral ratio (C:P ratio) as the key determinant of the lung deposition and distribution of aerosols within the airway tree.

The C:P ratio normalises the distribution of each aerosol (i) by using a ratio and (ii) adjusting for ventilation patterns. This is particularly important because individual central and peripheral deposition reporting and measurements, especially those relating to the peripheral airways, are subject to significant heterogeneity of ventilation, which in turn cause heterogeneity of deposition of the inhaled aerosol (Newman S *et al* 2012). Indeed, numerous studies confirm the C:P ratio as an accepted marker of lung distribution pattern of inhaled therapies (Virchow *et al* 2018).

A low C:P ratio (<1) indicates more deposition in the small airways, whereas a high C:P ratio (>1) indicates more deposition in the central airways. Studies have shown that extrafine formulations of inhaled therapies have a lower C:P ratio compared to non-extrafine formulations (Watz *et al* 2021, Usmani *et al* 2020), and hence the greatest proportional small airway deposition. This is of significant relevance given that small airways are often the primary site of inflammation in both asthma and COPD.

Particle size by MMAD across inhalers in the UK market

Particle size characteristics differ substantially across inhalers currently available in the UK. Table 1 (below) demonstrates the range of MMAD values contained within a range of ICS/LABA or ICS/LABA/LAMA inhalers on the UK market, showing Fostair and Trimbow contain notably smaller particle sizes than several other inhalers:

Table 1: Particle sizes of brand originator ICS/LABA and ICS/LABA/LAMA products

Brand name	Fostair		Symbicort		Seretide		Relvar	
Composition	Beclometasone	Formoterol	Budesonide	Formoterol	Fluticasone	Salmeterol	Fluticasone	Vilanterol
MMAD	1.3µm ²	1.5µm ²	-	-	-	-	4.2µm ²	2.3µm ²
Mean MMAD	1.4-1.5µm		3.1–3.3µm		3.1µm		-	

(Jetzer *et al* 2018, Varacca *et al* 2023)

Brand name	Trimbow			Trelegy			Trixeo		
Composition	Beclometasone	Formoterol	Glycopyrronium	Fluticasone	Vilanterol	Umeclidinium	Budesonide	Formoterol	Glycopyrronium
MMAD	-	-	-	-	-	-	-	-	-
Mean MMAD [‡]	1.1µm			2.4 - 4.4µm [‡]			3.3 - 3.5µm [‡]		

[‡]Average particle size of components at 30L/min flow rate.

(Trimbow pMDI 87/5/9 SPC (Enclosure 5, Usmani *et al* 2023))

Further research confirms that MMAD values for extrafine formulation Trimbow were consistently lower than those of non-extrafine formulations of Trixeo (BUD/FF/G) and

Trelegy (FLU/VI/UMEC), with Trimbaw (BDP/FF/G) demonstrating a correspondingly higher mean extrafine particle fraction (BDP/FF/G 39.0%–39.9%; BUD/FF/G 10.5%–16.2%; FLU/VI/UMEC 6.8%–27.7%). It is concluded in this research that these results suggest a greater potential to target the small airways (Lipworth *et al* 2025).

ii. Allegations of emphasis, disparagement or comparison

The complainant alleges that using capital letters draws the attention of the viewer and suggests it places undue emphasis on the claim. However, upon viewing the Video, the PMCPA will see that **all** text within the video is in capital letters for stylistic consistency. No disproportionate emphasis has been given to this statement over any other in the Video.

The complainant also alleges the claim is disparaging to '*several currently licensed inhalers available for treatment of asthma and COPD as many inhalers currently available have particle sizes that do sufficiently target both the large and small airways*'. Chiesi strongly rejects this assertion. The claim does not identify or imply which inhalers may fall within the category of '*some conventional DPIs and pMDIs*', nor does it imply superiority. The claim is a factual and objective reflection of the range of particle sizes across different dual and triple therapy inhalers available in the UK marketplace (see Table 1 above), based on aerosol science data and is fully substantiable (Hasan *et al* 2021).

Furthermore, there is no direct or indirect mention of any other company, product or device within this claim, nor a claim of superiority and therefore cannot be disparaging. Importantly, the claim uses the qualifier '*some*' and not all conventional pMDIs and DPIs. Therefore, a healthcare professional could not interpret the statement as a comparison with, or criticism of, any specific inhaler, nor could they draw any conclusion as to which inhaler primarily targets the large airways, and which targets both the large and small airways.

For these reasons, Chiesi maintains that the claim is non-comparative, non-disparaging, factual and fully substantiated, and therefore **not in breach of Clauses 6.1, 6.2 or 6.6**.

(b) Complaint regarding the claim: '*With Chiesi's extrafine particles you can reach and treat the small airways*'

The complainant alleges, in reference to this claim, that '*there is no robust clinical evidence to show that Trimbaw and Fostair's extrafine particles provide a clinical benefit (treat the small airways) or that they provide a clinical benefit (treat the small airways) compared with other licensed treatments*', and states that Chiesi has '*not conducted any direct studies or head-to-head studies to demonstrate clinical superiority*'. The complaint alleges that making such a claim '*is both misleading and incapable of substantiation*'.

i. Clarification on the claims within the Video

Chiesi firmly rejects the allegation this claim is misleading, comparative or implies clinical superiority. There is no direct or indirect mention within this claim of any other

device, inhaled medication or licensed treatment, nor any claim of clinical superiority. It simply reflects the well-established scientific fact that Chiesi's extrafine particles can reach (Usmani *et al* 2022, Usmani *et al* 2020, Scichilone 2013, Virchow *et al* 2018, De Backer 2010) and also treat the small airways (Carpagnano 2024, Baldi *et al* 2020, Gogali *et al* 2025, Vos *et al* 2013, De Backer *et al* 2015, Papi A *et al* 2007, Calverley PMA *et al* 2010, Pisi *et al* 2021). Further details are set out in Table 2 below.

It is therefore incorrect to suggest that the Video links extrafine particles to broader clinical benefits or outcomes that are not substantiated. The video refers only to reaching the small airways (i.e. deposition) and treating them (measured by functional markers of small airways disease). It does not extend these points to clinical benefits on patients' outcomes – although such evidence exists and is robust. Improvement in clinical endpoints through use of extrafine compared to non-extrafine particle inhalers have been demonstrated in COPD Assessment Test Score (CAT Scores) and health status (Gogali *et al* 2025), functional exercise capacity (Calverley PMA *et al* 2010) and in hyperinflation (Watz *et al* 2024, De-Backer *et al* 2015) in COPD patients, and on asthma control in asthma patients (Vos *et al* 2013, Huchon *et al* 2009).

ii. Evidence supporting small airway treatment

Many studies confirm how Trimbow and Fostair can treat the small airways in both asthma and COPD, demonstrated through changes in small airways function using oscillometry (R5-R20, R5-R19, X5, AX, Fres, IOS) spirometry (% FEF 25-75), FRI measures (siVaw, siRaw) or inflammatory markers (FeNO).

The complainant provides no framework for which markers they consider adequate to demonstrate treatment of the small airways, however evidence substantiating the effect from numerous markers is shown below:

Table 2: Supporting evidence for treating the small airways

Reference	Summary
Calverley et al. 2010. Respir Med; 104(12): 1858-68	COPD patients receiving extrafine formulation BDP/FF experienced significantly reduced air trapping compared to baseline, demonstrated by change in FVC at 48 weeks. In a double-blind, double-dummy, randomised, active-controlled, parallel-group study of 718 patients with COPD patients were randomised to receive BDP/FF (200/12 µg pressurised metered dose inhaler), BUD/FF (400/12 µg dry powder inhaler) or FF (12 µg dry powder inhaler) twice daily for 48 weeks. Co-primary efficacy variables were change from baseline to 48 weeks in pre-dose morning forced expiratory volume in 1 s (FEV(1)) and mean rate of COPD exacerbations.

Reference	Summary
	In severe stable COPD patients receiving extrafine formulation BDP/FF, a mean increase in FVC from baseline of 0.09 L was observed 48 weeks post-initiation (p=0.005). No significant change in FVC from baseline was observed in patients receiving non-extrafine formulation budesonide/formoterol (0.05 L; p=0.152) or formoterol (0.02 L; 0.582). Improvement in FVC may indicate a reduction of air trapping associated with small airways patency.
Carpagnano et al. 2024. J Clin Med; 13(8): 2320.	Switching from a non-extrafine open triple therapy (ICS/LABA + LAMA [non efMITT]) to a single-inhaler extrafine formulation BDP/FF/G [efSITT] in adults with severe asthma and a SAD phenotype, for 3 months produced significant improvements in small airway function, reduced small airway inflammation, and improved overall clinical control. Switching from non efMITT (ICS/LABA + LAMA) to efSITT (BDP/FF/G 172/5/9 mcg pMDI, 2 puffs b.d) in adults with severe uncontrolled asthma at 3 months resulted in a significant improvement in small airway function, with a mean increase in %FEV₂₅₋₇₅ from 48.53 at baseline to 63.62 at 3 months (31% increase, p 0.001). Median airway resistance (R₅₋₂₀ Hz) decreasing from 0.14 at baseline to 0.07 at 3 months (50% reduction, p < 0.001). Mean residual volume percentage (%RV) was reduced from 165.70 at baseline to 141.65 at 3 months (14.51% reduction, p = 0.001). Median reactance markers, F_{res} from 20.90 to 16.33 (p < 0.001), A_X from 1.25 to 0.77 (p < 0.001), and X₅ -1.20 to -0.55 (p < 0.001), demonstrated significant improvement at three months compared to baseline. Switching from non-efMITT to efSITT significantly reduced airway inflammation, with a decrease in FeNO at 350 mL/s from 21.81 at baseline to 9.31 at 3 months (57% reduction, p<0.001) indicating reduced airway inflammation

Reference	Summary
Baldi et al. 2020. CHEST; 158(4S): 1664A.	Switching from a non-extrafine formulation multiple inhaler triple therapy (non-efMITT) to extrafine formulation BDP/FF/G (efSITT) in symptomatic patients with severe COPD caused a significant bronchodilation effect at week 24, as demonstrated through peripheral airways deposition signatures (FRI). Switching from non efMITT (ICS/LABA + LAMA) to efSITT (BDP/FF/G 87/5/9 mcg pMDI, 2 puffs b.d) in symptomatic patients with severe COPD at week 24, resulted in a 22% increase ($p<0.001$) in siVaw and a reduction of 17.6% ($p=0.014$) in resistance (siRaw) at TLC, when compared to baseline. The change from baseline in SGRQ total score was inversely correlated to siVaw ($r=-0.470$, $p=0.042$), though the change from baseline in FEV1 showed no correlation to either siVaw ($r=0.299$, $p=0.214$) or siRaw ($r=-0.349$, $p=0.143$). Switching from non efMITT to efSITT increased peripheral lung deposition of ICS by 19.8% $\pm$3.8%, LABA by 18.8%$\pm$3.4% and LAMA by 13.2%$\pm$7.1% when compared to delivered dose, respectively.
Gogali et al. 2025. Int J Chron Obstruct Pulmon Dis; 20: 1651–1663.	Switching from non-extrafine LABA/LAMA dual therapy to extrafine single-inhaler triple therapy (BDP/FF/G [efSITT]) in symptomatic COPD patients with SAD for 4 weeks produced significant improvements in small airway indices (oscillometry parameters), alongside clinically relevant improvements in lung function and quality of life. Switching from non-extrafine LABA/LAMA dual therapy to efSITT (BDP/FF/G 87/5/9 mcg pMDI, 2 puffs b.d) in symptomatic COPD patients with SAD for 4 weeks resulted in a significant reduction of mean peripheral airway resistance (R5-19; difference between resistance at 5 and 19 Hz) by -0.49 cmH₂O/L/s ($p<0.0001$), compared to baseline. There were also improvements in reactance (Fres - 3.45 Hz, $p<0.0001$; AX -7.58 cmH₂O/L, $p<0.0001$; X5 -0.99 cmH₂O/L/s, $p<0.0001$), lung function (%FEF25-75 increase by

Reference	Summary
	3.43%, $p=0.0005$; FEV ₁ gain by 142 mL, $p<0.0001$) and health score (CAT score -4.09 points, $p<0.0001$) compared to baseline. The change in CAT score is correlated with R5-19 improvement ($r=0.40$; $p<0.0001$).
De Backer et al. 2015. J Aerosol Med Pulm Drug Deliv; 28(2): 88-99.	Switching from non-extrafine formulation LABA, LAMA and ICS/LABA combinations to extrafine formulation BDP/FF in COPD patients for 6 months produced a significant small airway bronchodilation effect post-dose (increase in volume and decrease in resistance) and reduced lobar hyperinflation at total lung capacity, as demonstrated through functional respiratory imaging (FRI). Switching from non-extrafine formulation combinations of LABA, LAMA and ICS/LABA to extrafine formulation BDP/FF (100/6 mcg pMDI, 2 puffs b.d.) in COPD patients for 6 months resulted in a significant acute increase (10.5%; $p<0.00001$) in specific airway volume (siVaw) and a concomitant reduction (-34.8%; $p<0.00001$) in airway resistance (iRaw) at TLC, as assessed by functional respiratory imaging (FRI) 4–6 hours post-dose. After 6 months, no significant changes in pre-bronchodilation siVaw ($p=0.65$) and iRaw ($p=0.16$) were seen compared with the pre-bronchodilation values at baseline, whereas pre-bronchodilation lobar hyperinflation at TLC was significantly reduced (-1.19% predicted, $p=0.009$), particularly in ICS-naïve patients. Patients who reported an improvement in dyspnea (improvement in MMRC score ≥ 1) showed a significant reduction in lobar hyperinflation at TLC ($p=0.0024$) compared to patients who reported a decline in MMRC by 1 or greater.
Papi et al. 2007. Allergy; 62(10): 1182-8	In moderate to severe asthma patients receiving extrafine formulation BDP/FF experienced significantly reduced air trapping, demonstrated by change from baseline FVC, at 2 weeks compared to non-extrafine formulation FP/S.

Reference	Summary
	The analysis of noninferiority on the primary outcome, morning peak expiratory flow in the last 2 weeks of treatment, showed no difference between groups (difference -3.32 l/min; 95% CI -17.92 to 11.28). In moderate to severe asthma patients receiving extrafine formulation BDP/FF, a mean increase in FVC from baseline of 0.46 L was observed 2 weeks post-initiation, compared to 0.34 L in patients receiving non-extrafine formulation FP/S ($p=0.040$) ($p<0.001$). This change in FVC is consistent with a greater reduction in air trapping and small airways obstruction. In addition, a significant improvement in symptom score and rescue medication use was observed in both groups at all time points.
Pisi et al. 2021 Pulm Ther; 7(1): 133-143.	Treatment with extrafine formulation BDP/FF for 12 weeks in COPD patients with small airway disease (SAD) produced statistically significant improvements in small airway indices (R5–R20, X5), lung function (FEV₁, RV/TLC), and health status (CAT scores), providing evidence that improvements in SAD parameters achieved with BDP/FF resulted in benefits in relevant COPD disease outcomes. COPD patients with SAD and a history of one moderate exacerbation in the previous year were treated with extrafine formulation of BDP/FF for 12 weeks. There was a significant reduction of peripheral airway resistance (R5–R20) from baseline [0.23 ± 0.09 kPa/(l/s)] to V3 [0.16 ± 0.08 kPa/(l/s)] ($p < 0.05$). There were also improvements in reactance (X5 from baseline [-0.34 ± 0.13 kPa/(l/s)] to V3 [-0.27 ± 0.15 kPa/(l/s)] ($p < 0.05$). Lung function improved, with FEV₁ increasing by 230 mL from baseline ($1.21 \text{ L} \pm 0.33$) to V3 ($1.44 \text{ L} \pm 0.43$) ($p < 0.05$). RV/TLC decreased by 6% from baseline ($59\% \pm 7$) to V3 ($53\% \pm 7$) ($p < 0.05$). Health status improved, with the CAT score decreasing by 9 points from baseline (13 [11–17]) to V3 (4 [3–7]) ($p < 0.05$). A correlation was found between CAT percentage change values and the corresponding ones of R5–R20

Reference	Summary
	($r = -0.329$, $p = 0.045$) and RV/TLC ($r = 0.354$, $p = 0.029$), suggesting that improvements in SAD parameters are associated with improvements in relevant COPD disease outcomes.

ACT: Asthma Control Test; **AX:** area of reactance; **b.d.:** twice daily; **BDP:** beclometasone; **CAT:** COPD assessment test; **CFD:** computational fluid dynamics; **ef:** extrafine; **FEF:** forced expiratory flow; **FeNO 50:** fractional exhaled nitric oxide at 50 mL/s; **FeNO 350:** fractional exhaled nitric oxide at 350 mL/s; **FF:** formoterol; **Fres:** resonant frequency; **FRI:** Functional respiratory imaging; **FVC:** Forced vital capacity; **G:** glycopyrronium; **ICS:** Inhaled corticosteroids; **IOS:** Impulse Oscillometry; **iRaw:** image-based airway resistance; **iVaw:** image-based small airway volume; **LABA:** long-acting beta2-agonist; **LAMA:** long-acting muscarinic antagonist; **MITT:** multiple inhaler triple therapy; **mMRC:** modified medical research council; **RV:** residual volume; **SABA:** short-acting beta2-agonist; **SAD:** Small Airway Disease; **siVaw:** specific image based inner airway volume; **SITT:** single inhaler triple therapy; **TLC:** total lung capacity; **SRGQ:** St George's respiratory questionnaire; **X5:** reactance at 5 Hz.

iii. Expert validation of the evidence base

During the development of the claims, Chiesi sought external consultancy from leading, internationally recognised respiratory small airways disease experts. These experts independently concluded that the totality of evidence, including the studies stated above, is sufficiently comprehensive to support claims that extrafine formulations of Fostair and Trimbaw can treat small airways disease:

'I think as a total body of evidence it's quite compelling' [in terms of being able to substantiate the treat aspect of the claim] **Clinical Professor of Respiratory Medicine**

'I think there is no doubt that the evidence presented across the multiple studies is strong. It comes from multiple centres, different study designs and is reflective of the real-life situation.' **Consultant Respiratory Physician**

[Asked if there is a sufficiently comprehensive body of evidence to support a claim of treating the small airways with extrafine formulations] *'I think as a top line, you do have enough'* **Professor of Respiratory Pharmacology**

[When asked if there is sufficient data to discuss treating the small airways with extrafine formulations] *'I think you do so and yes'* **Professor of Respiratory Medicine**

These independent scientific opinions support Chiesi's position that the claim is accurate and fully substantiated.

iv. Compliance with licensed indications and patient safety

Chiesi maintains that the Video promotes both Fostair and Trimbaw strictly within their respective licensed indications for COPD:

- Fostair pMDI and NEXThaler 100/6:
Symptomatic treatment of patients with severe COPD ($FEV_1 < 50\%$ predicted normal) and a history of repeated exacerbations, who have significant symptoms despite regular therapy with long-acting bronchodilators.

- Trimbow pMDI 87/5/9 and NEXThaler 88/5/9:
Maintenance treatment in adult patients with moderate to severe COPD who are not adequately treated by a combination of an inhaled corticosteroid and a long-acting beta2-agonist or a combination of a long-acting beta2-agonist and a long-acting muscarinic antagonist (for effects on symptoms control and prevention of exacerbations see section 5.1).

Both products have been approved through the robust regulatory frameworks of the MHRA and EMA. Promotion in line with their Marketing Authorisations there cannot prejudice patient safety. Therefore there is no breach of Clause 2.

The claim that '*With Chiesi's extrafine particles you can reach and treat the small airways*' is accurate, evidence-based, non-comparative and fully substantiated. The extensive scientific literature, expert opinion and functional airway data referred to above support the claim that both Fostair and Trimbow reach and treat the small airways. There has been no claim of clinical superiority in favour of Fostair or Trimbow over other competitor products or device. **Chiesi therefore strongly disputes breaches of Clauses 6.1, 6.2, 5.1 or 2 and maintains that there are no concerns regarding patient safety and that high standards have been upheld throughout.**

(c) Complaint: '*The video overall is not appropriate as extrafine formulations/extrafine particle size merely refer to the dosing considerations of using Fostair and Trimbow ... Chiesi have extrapolated the product formulation/particles to falsely and incorrectly claim that there is a superior benefit clinically.*'

The complainant alleges that the video makes inappropriate claims or implies unfounded superior clinical benefit. Chiesi firmly rejects this allegation. The complainant suggests that extrafine formulations relate only to dosing considerations and that Chiesi has extrapolated particle size characteristics into unjustified clinical claims. This is incorrect.

i. Clinical relevance of the extrafine formulation

Fostair and Trimbow are characterised by an extrafine particle size distribution, a fact not been disputed by the complainant. This is a fundamental and clinically relevant feature of these products. As detailed in the SPCs (Enclosures 5–11), 100 mcg of beclometasone extrafine in Fostair or Trimbow is equivalent to 250 mcg of beclometasone in a nonextrafine formulation, demonstrating the increased potency associated with the extrafine formulation.

ii. Evidence demonstrating treatment of the small airways

As demonstrated in Table 2 above, there is a substantial and consistent body of evidence supporting the ability of Trimbow and Fostair to treat the small airways. These

studies also provide evidence of associated benefits in clinical outcomes, including positive effects on CAT score and health status in COPD patients (Gogali *et al* 2025) and on asthma control in asthma patients (Vos *et al* 2013) compared with non-extrafine formulations.

iii. Accurate interpretation of the Video contact

Importantly, the Video itself does not claim any subsequent improvement in clinical benefits or patient outcomes, or any form of superiority over another particular medicine or device, as alleged by the complainant. It refers solely to treating the small airways with Fostair and Trimbaw. The complainant's interpretation therefore mischaracterises the content of the video.

iv. Supporting evidence for clinical benefits of extrafine formulations

Furthermore, although the Video does not claim superior clinical benefit versus other treatments, it is nevertheless noteworthy that such superiority can, in fact, be substantiated. A meta-analysis of seven studies with 33,453 subjects evaluated the effectiveness of an extrafine particle inhaled corticosteroid compared to a non-extrafine particle inhaled corticosteroid. Six studies used extrafine particle beclometasone and one study used both extrafine beclometasone and extrafine particle ciclesonide as comparators with fine-particle inhaled corticosteroids. The overall odds of achieving asthma control were significantly higher for extrafine particle inhaled corticosteroids compared with fine-particle inhaled corticosteroids (OR, 1.34; 95% CI 1.22-1.46). Overall exacerbation rate ratios (0.84; 95% CI 0.73-0.97) were significantly lower for extrafine particle ICSs compared with fine-particle ICSs. This evidence clearly supports the clinical benefits and value of an extrafine formulation inhaler. (Sonnappa 2018)

Given the extensive evidence basis, the alignment of claims and promotion in accordance with the Marketing Authorisations and SPCs, and the strong external expert support for the scientific validity of the statements made, Chiesi strongly disputes any suggestion that the Video is inappropriate or in any way a breach of the Code. To the contrary, the Video maintains high standards, is fully consistent with licensed indications and does not pose any risk to patient safety. Therefore, Chiesi fully rejects the allegations that the Video breaches Clauses 5.1 and 2.

5. Conclusion

For the reasons comprehensively set out above, Chiesi submits that the Video and the Webpage fully comply with the requirements of the Code. Specifically:

- The statement regarding '*some conventional DPIs and pMDIs release particles too large to target the small airways*' is factual, fair, fully-substantiated, non-comparative and not disparaging and therefore does not breach Clauses 6.1, 6.2, 6.6 of the Code.
- The statement '*With Chiesi's extrafine particles you can reach and treat the small airways*' is accurate, evidence-based, non-comparative, and entirely within licensed indications, and therefore does not breach Clauses 6.1, 6.2, 5.1, 2 of the Code.

- The materials uphold high standards and pose no risk to patient safety, and there do not breach Clauses 5.1 or 2.

In light of the robust scientific evidence, supported by expert opinion, and clear alignment within the marketing authorisations, Chiesi respectfully invites the Panel to rule no breach of Clauses 2, 5.1, 6.1, 6.2, and 6.6.”

PANEL RULING

This case related to a promotional video hosted on a Chiesi website that was allegedly misleading, incapable of substantiation and disparaging to competitor products.

The video was hosted on the extrafine formulation page of the Chiesi Air website which included four sections: Small airways disease; A hidden risk; Extrafine formulation treatments; and Clinical evidence.

At the top of the webpage appeared a large banner containing information similar to the video in question with buttons to learn more or watch the video. Directly beneath were four tabs that allowed readers to navigate directly to the corresponding section.

The Panel noted that the video itself appeared within the “A hidden risk” section and was preceded by the text *“Explore the hidden risk of small airways disease, and how our extrafine formulation portfolio can help reach and treat both the large and small airways”*. This was followed by the “Extrafine formulation treatments” and “Clinical evidence” sections which included information on Fostair (beclometasone/formoterol) and Trimbow (beclometasone/formoterol/glycopyrronium).

The video in question was 1 minute and 54 seconds long. The opening frame of the video consisted of the Chiesi logo, followed by a frame containing the brand and generic names for both Fostair and Trimbow with their respective indications in COPD and asthma, along with signposting to prescribing information and adverse event reporting information. The following text appeared across numerous frames:

~90% OF PATIENTS WITH ASTHMA AND SYMPTOMATIC COPD; ARE AFFECTED BY; SMALL AIRWAYS DISEASE ([Footnote] - *Based on an observational study (N=202) involving patients with symptomatic COPD defined as a CAT score ≥10, and a prospective cohort study (N=773) involving asthma patients); A BIG RISK; HIDDEN DEEP IN THE; ‘SILENT ZONE’; OF THE LUNGS; HARD TO DETECT USING SPIROMETRY; IT CAN DRIVE EXACERBATIONS; AND REDUCE QUALITY OF LIFE; SOME CONVENTIONAL pMDIs AND DPis; RELEASE PARTICLES TOO LARGE TO; TARGET THE SMALL AIRWAYS; WITH CHIESI’S EXTRAFINE PARTICLES; YOU CAN REACH AND TREAT THE SMALL AIRWAYS; THE ONLY PORTFOLIO OF PRODUCTS WITH AN EXTRAFINE FORMULATION, AVAILABLE IN A RANGE OF STRENGTHS AND DEVICES”*

This was followed by frames which included images of different Trimbow and Fostair inhalers along with the following text:

“FOR YOUR ELIGIBLE ADULT PATIENTS WITH ASTHMA AND COPD; TREAT THE SMALL AIRWAYS; WITH CHIESI’S PORTFOLIO OF EXTRAFINE FORMULATION INHALERS”

The Panel understood the allegations to primarily relate to two claims.

Claim 1: “Some conventional DPIs and pMDIs release particles too large to target the small airways”

The Panel understood the complainant’s allegation to be that the comparative claim, which followed messaging on exacerbations and quality of life, disparaged several currently licensed inhalers for asthma and COPD as many inhalers “have particle sizes that do sufficiently target both large and small airways”. The complainant further alleged that there was no qualification in the video as to which conventional inhalers were being referred to and that the claim was “non-objective” and “unfair”.

Chiesi submitted that the statement was taken directly from a referenced source, Hasan et al 2021, and provided data illustrating variation in particle size between a number of inhalers. Chiesi further submitted that the qualification of “some” made clear the claim did not apply to all conventional inhalers and that no competitor medicine or device was referred to.

The Panel considered the claim in the context in which it appeared, as part of a short promotional video for Fostair and Trimbrow. The video included that small airways disease could drive exacerbations and contrasted “some conventional pMDIs and DPIs” which released particles too large to target the small airways with Chiesi’s extrafine particles which could “reach and treat the small airways”.

The Panel noted the complainant’s concern that the claim appeared in capital letters and accepted Chiesi’s submission that all text in the video, with exception to acronyms and footnotes, appeared in capital letters. The Panel did not consider that the claim highlighted by the complainant had been given particular emphasis in this regard.

The Panel took into account that the claim expressly referred to “some” conventional DPIs and pMDIs, did not identify any particular medicine or inhaler and was referenced to Hasan *et al* 2021. The Panel also took account of the preceding messaging that small airways disease could drive exacerbations and reduce quality of life. In the circumstances of this case, the Panel did not consider that the complainant had established that the claim, in context, disparaged other inhalers for asthma and COPD. Nor did the Panel consider that it had been established that the claim was non-objective, unfair or required further qualification as alleged such that it was misleading. The Panel therefore ruled **no breach of Clauses 6.1 and 6.6**.

Whilst the complainant cited Clause 6.2, the complainant had not otherwise explained why the claim was incapable of substantiation. It was not for the Panel to infer detailed reasons to support an allegation on behalf of the complainant. The Panel ruled **no breach of Clause 6.2**.

Claim 2: “With Chiesi’s extrafine particles you can reach and treat the small airways”

The Panel understood the latter part of the complaint to be that the claim linked and extrapolated the extrafine particle formulation of Fostair and Trimbrow to a clinical benefit in treating the small airways when, according to the complainant, there was no robust clinical evidence to support this, including compared with other licensed inhalers. In this regard, the

complainant stated there were no direct or head-to-head studies and alleged that the claim was misleading and incapable of substantiation.

The Panel took into account that the claim immediately followed the statement that “some conventional pMDIs and DPIs release particles too large to target the small airways” and was followed by the claim “the only portfolio of products with an extrafine formulation, available in a range of strengths and devices”, along with images of Fostair and Trimbow inhalers.

The Panel noted the use of the word “treat” and considered that the claim went beyond a statement concerning particle size or deposition alone. In the Panel’s view, the claim linked the extrafine formulation of Fostair and Trimbow with a clinical effect on the small airways. However, the Panel did not consider it had been established that this link to clinical benefit was misleading as alleged. In this regard, the Panel noted Chiesi provided a number of studies which it submitted demonstrated that Fostair and Trimbow could reach and treat the small airways.

The Panel further noted that the claim did not expressly refer to any other inhaled medicine or formulation, nor did it state that Chiesi’s extrafine formulations were clinically superior to another product or formulation. Whilst the claim followed reference to some conventional inhalers releasing particles too large to target the small airways, the Panel did not consider the claim implied that Fostair or Trimbow provided a superior clinical benefit in treating the small airways such that it required supporting direct or head-to-head studies.

In light of the above, the Panel did not consider that the complainant had established that the claim was misleading or incapable of substantiation. The Panel therefore ruled **no breach of Clauses 6.1 and 6.2.**

Overall: High standards and patient safety

In relation to the video overall, the complainant alleged that the video failed to maintain high standards and risked patient safety because the extrafine formulation and particle size were merely dosing considerations and the claimed clinical benefit was based on a weak hypothesis.

The Panel considered that the complainant’s concerns regarding the link between the extrafine formulation and clinical benefit had been adequately addressed by its rulings above. Given those rulings, the Panel did not consider that the complainant had established that Chiesi had failed to maintain high standards or that the video risked patient safety as alleged. The Panel therefore ruled **no breach of Clauses 5.1 and 2.**

Complaint received 3 December 2025

Case completed 21 August 2026