A Unified Front Against COPD: Clinical Practice Guidelines From the American College of Physicians, the American College of Chest Physicians, the American Thoracic Society, and the European Respiratory Society

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A Unified Front Against COPD

Clinical Practice Guidelines From the American College of Physicians, the American College of Chest Physicians, the American Thoracic Society, and the European Respiratory Society

COPD is one of the world’s leading causes of morbidity and mortality. Currently the fifth leading cause of death worldwide, it is predicted that COPD will become the third leading cause of death by the year 2020. In fact, COPD already has surpassed cerebrovascular disease to become the third leading cause of death in the United States. In addition, COPD is now recognized as a life-limiting illness that imposes significant symptom burden on those with the disease. The varied and diverse pathology of COPD, which is caused by cigarette smoke exposure in the majority of patients, typically involves multiple components, including small airway inflammation and remodeling, mucociliary dysfunction, and lung architecture damage. These pathologic changes lead to airflow limitation, resulting in gas trapping and hyperinflation, with resultant disability and handicap.

The diagnosis of COPD is based fundamentally on spirometric measurement, which demonstrates airway obstruction that may be partially reversible. Because of the slow progression of the disease over years, symptoms early in the course are subtle and insidious, resulting in delay in seeking medical advice, early diagnosis, and appropriate management. In a recent study performed in primary-care practice, 20% of patients with risk factors for COPD met spirometry criteria for moderate, severe, or very severe COPD, which highlights the reality that underdiagnosis of COPD in primary care is widespread. The goals of COPD management aim to improve symptoms, lung function, and health status and to reduce exacerbations, disease progression, and mortality. To achieve these goals, several effective pharmacologic and nonpharmacologic interventions need to be implemented on the basis of disease severity and patient symptoms. Although such interventions have led to striking successes in patient-focused outcomes, there is much more that needs to be done to overcome the rising burden of this disease and to improve therapeutic outcomes.

Several guidelines for COPD have been published to date. Although these guidelines aim to optimize the diagnosis and management of COPD, many issues exist that affect their practical implementation. One important issue is that each guideline addresses a different audience and targets different geographic locales. To unify and improve our approach to this disease, the American College of Physicians (ACP), American College of Chest Physicians, American Thoracic Society, and European Respiratory Society recently released an updated clinical practice guideline for COPD. This guideline tackles several important issues and updates a previous ACP document published in 2007. Although the guideline highlights that history and physical examination in isolation are not sensitive for use in the diagnosis of COPD, clinicians should be aware that many patients may deny symptoms because they have already restricted their activities to those that would not cause symptoms. Patients with very low daily levels of activity indeed may be symptomatic if they were to engage in activities normal for persons their age. Therefore, it is imperative to actively question patients about their daily activities and not to restrict questions to symptoms alone.

There continues to be a strong recommendation to use spirometry for the early diagnosis of COPD in patients with respiratory symptoms, but evidence does not support the use of “screening spirometry” in those without respiratory symptoms. The new guideline now suggests that inhaled bronchodilators may be used effectively in patients with COPD with respiratory symptoms and an FEV₁ between 60% and 80% predicted. In patients with more progressed disease (FEV₁ < 60% predicted) in whom combination therapy may be considered, this recommendation is even stronger. However, clinical gaps in knowledge regarding pharmacologic therapy in patients with mild or asymptomatic COPD are still present. Although there is a paucity of reported research examining therapies in this population to support any recommendations at this point, one must keep
The guideline emphasizes the importance of pulmonary rehabilitation, which should be considered in symptomatic patients with an FEV$_1$ < 50% predicted. Pulmonary rehabilitation also may be considered in symptomatic or exercise-limited patients with an FEV$_1$ > 50%, as endorsed elsewhere. The guideline continues to recommend supplemental oxygen therapy for patients with severe resting hypoxemia (Pao$_2$ ≤ 55 mm Hg or arterial oxygen saturation of ≤ 88%).

COPD has become a global medical urgency. Our awareness, attitudes, and acceptance of the burden and consequences of COPD for patients, families, physicians, and health-care systems have to knowingly change. COPD has an important negative impact on patient health, and the meaningful patient-centered benefits of optimizing pharmacologic and nonpharmacologic therapies can no longer be ignored or minimized. The new clinical practice guideline on COPD from the American College of Physicians, the American College of Chest Physicians, the American Thoracic Society, and the European Respiratory Society takes an important step forward by highlighting an evidence-based and unifying approach to the diagnosis and management of COPD. It is now time for the rest of us to roll up our sleeves and put these guidelines to work for the millions of patients with COPD who will benefit from their implementation.

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