Helping Your Patients with COPD Get Back to Activity

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Disclosure

I have no actual or potential conflict of interest in relation to this presentation.

Goals and Objectives

1. Recognize COPD that is underdiagnosed and misdiagnosed
2. Understand role of spirometry in diagnosis and management
3. Assess for symptoms and risk of exacerbations
4. Use the GOLD ABE assessment tool
5. Pursue appropriate pharmacologic and non-pharmacologic therapy to optimize quality of life and limit exacerbations

Excluded Topics

- Differential diagnoses
- Indications for oxygen therapy
- Interventional therapy
  - Lung volume reduction surgery
  - Bullectomy
  - Transplantation
  - Bronchoscopic interventions
- Management of exacerbations
- Management of hospitalized patients

A Brief Story or Two

Recognition

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Clinical Indicators for Considering a Diagnosis of COPD

Figure 2.1

Consider the diagnosis of COPD, and perform spirometry, if any of these clinical indicators are present:
(these indicators are not diagnostic themselves, but the presence of multiple key indicators increases the probability of the presence of COPD; in any case, spirometry is required to establish a diagnosis of COPD)

Dyspnea that is	Progressive over time Worse with exercise Persistent
Recurrent wheeze	
Chronic cough	May be intermittent and may be non-productive
Recurrent lower respiratory tract infections	
History of risk factors	Tobacco smoke (including popular local preparations) Smoke from home cooking and heating fuels Occupational dusts, vapors, fumes, gases and other chemicals Host factors (e.g., genetic factors, developmental abnormalities, low birthweight, prematurity, childhood respiratory infections etc.)

Establishing the Diagnosis and Determining Severity of Airflow Obstruction

Spirometry

- Consider COPD in any patient who has:
  - Dyspnea
  - Chronic cough or sputum production
  - History of recurrent lower respiratory tract infections and/or history of exposure to risk factors

- Spirometry showing a post-bronchodilator FEV1/FVC <0.7 is mandatory to establish the diagnosis of COPD

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Role of Spirometry in COPD

Figure 2.7

- **Diagnosis**
- **Assessment of severity of airflow obstruction (for prognosis)**
- **Follow-up assessment**
  - Therapeutic decisions
    - Pharmacological in selected circumstances (e.g., discrepancy between spirometry and level of symptoms)
    - Consider alternative diagnoses when symptoms are disproportionate to degree of airflow obstruction
    - Non-pharmacological (e.g., interventional procedures)
  - Identification of rapid decline

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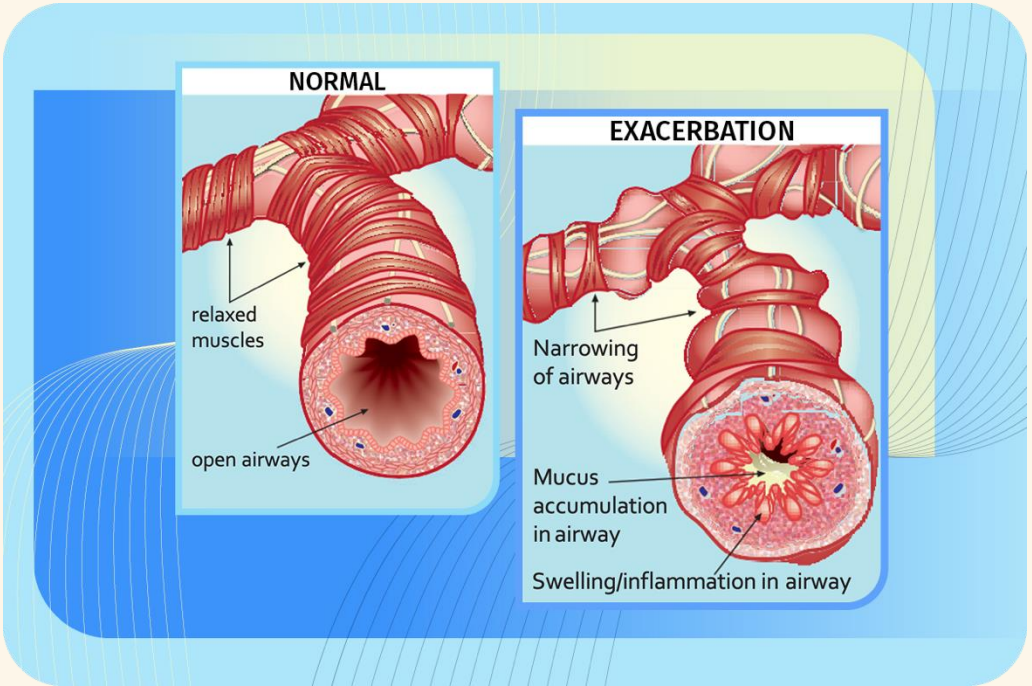
GOLD Grades and Severity of Airflow Obstruction in COPD (based on post-bronchodilator FEV1)

Figure 2.8

In COPD patients (FEV1/FVC < 0.7):

GOLD 1:	Mild	FEV1 ≥ 80% predicted
GOLD 2:	Moderate	50% ≤ FEV1 < 80% predicted
GOLD 3:	Severe	30% ≤ FEV1 < 50% predicted
GOLD 4:	Very Severe	FEV1 < 30% predicted

Assessing Symptoms and Risk of Exacerbations



Modified MRC Dyspnea Scale

Figure 2.9

PLEASE TICK IN THE BOX THAT APPLIES TO YOU | ONE BOX ONLY | Grades 0 - 4

mMRC Grade 0	mMRC Grade 1	mMRC Grade 2	mMRC Grade 3	mMRC Grade 4
I only get breathless with strenuous exercise ☐	I get short of breath when hurrying on the level or walking up a slight hill ☐	I walk slower than people of the same age on the level because of breathlessness, or I have to stop for breath when walking on my own pace on the level ☐	I stop for breath after walking about 100 meters or after a few minutes on the level ☐	I am too breathless to leave the house or I am breathless when dressing or undressing ☐

Reference: ATS (1982) Am Rev Respir Dis. Nov;126(5):952-6.

Risk of Exacerbations

- Exacerbations per year
- Hospitalizations for COPD

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GOLD ABE Assessment Tool

Figure 2.11

Spirometrically confirmed diagnosis → Assessment of airflow obstruction → Assessment of symptoms/risk of exacerbations

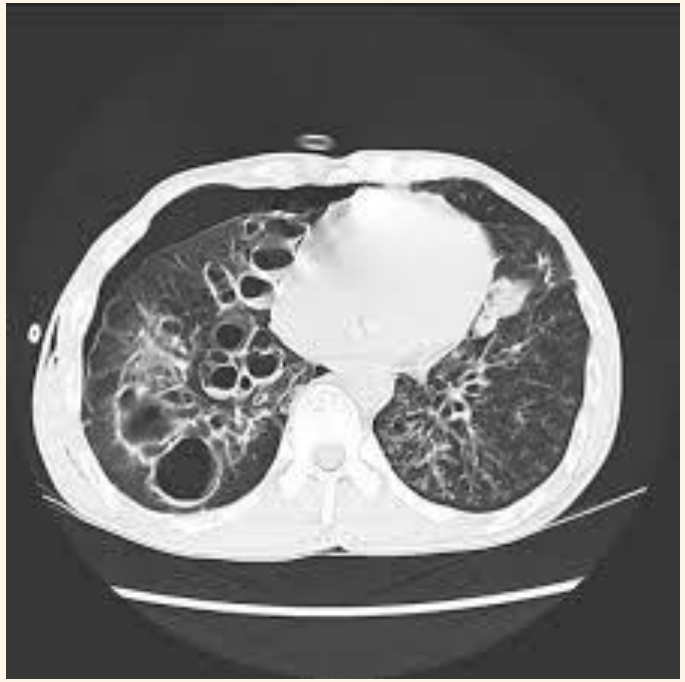
Post-bronchodilator FEV1/FVC < 0.7

GRADE	FEV1 (% predicted)
GOLD 1	≥ 80
GOLD 2	50-79
GOLD 3	30-49
GOLD 4	< 30

EXACERBATION HISTORY (PER YEAR)

	SYMPTOMS: mMRC 0-1 CAT < 10	SYMPTOMS: mMRC ≥ 2 CAT ≥ 10
≥ 2 moderate exacerbations or ≥ 1 leading to hospitalization	E	
0 or 1 moderate exacerbations (not leading to hospitalization)	A	B

Indications for Imaging



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Use of CT in Stable COPD

Figure 2.12

Differential Diagnosis	• Frequent exacerbations with excessive cough with sputum production, raising concern for bronchiectasis or atypical infection • Symptoms out of proportion to disease severity based on lung function testing
Lung Volume Reduction	• Endobronchial valve therapy may be a therapeutic option for patients if they demonstrate postbronchodilator FEV1 between 15% to 45% and evidence of hyperinflation • Lung volume reduction surgery may be a therapeutic option for patients with hyperinflation, severe upper lobe predominant emphysema and low exercise capacity after pulmonary rehabilitation
Lung Cancer Screening	• Annual low-dose CT scan is recommended for lung cancer screening in patients with COPD due to smoking according to recommendations for the general population

Treatment

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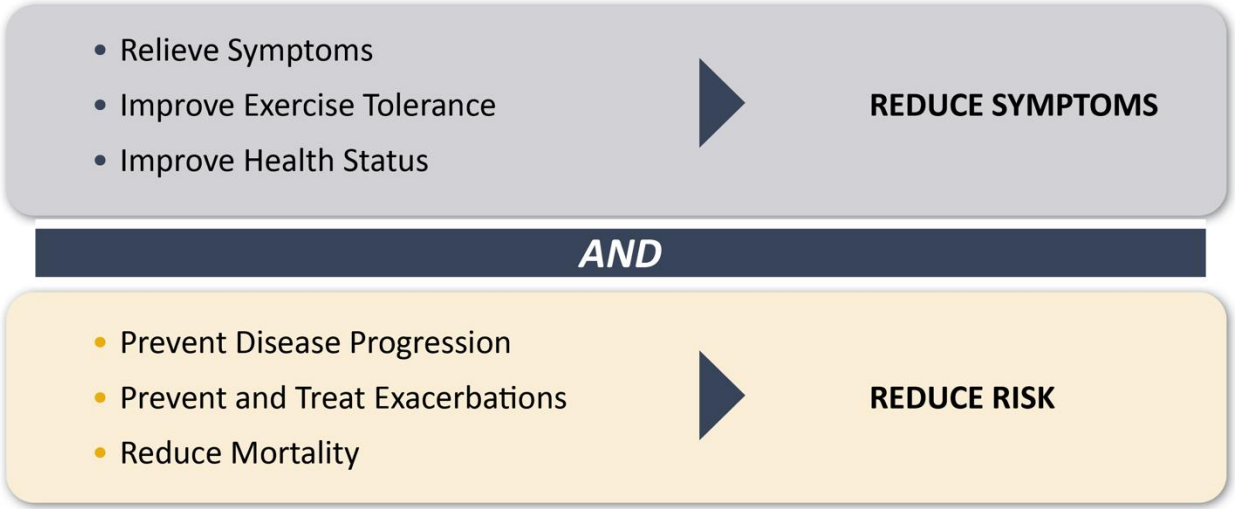
Goals for Treatment of Stable COPD

Figure 3.1



Non-Pharmacological Management

- Smoking cessation
- Physical activity
- Vaccinations
- Pulmonary rehabilitation
- Lung volume reduction surgery

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Pulmonary Rehabilitation, Self-Management and Integrative Care in COPD

Figure 3.24

Pulmonary Rehabilitation	• Rehabilitation is indicated in all patients with relevant symptoms and/or a high risk for exacerbation **(Evidence A)** • Pulmonary rehabilitation improves dyspnea, health status and exercise tolerance in stable patients **(Evidence A)** • Pulmonary rehabilitation reduces hospitalization among patients who have had a recent exacerbation (≤ 4 weeks from prior hospitalization) **(Evidence B)** • Pulmonary rehabilitation leads to a reduction in symptoms of anxiety and depression **(Evidence A)**
Education and Self-Management	• Education is needed to change patient's knowledge but there is no evidence that used alone it will change patient behavior **(Evidence C)** • Self-management intervention with communication with a health care professional improves health status and decreases hospitalizations and emergency department visits **(Evidence B)**
Integrated Care Programs	• Integrative care and telehealth have no demonstrated benefit at this time **(Evidence B)**
Physical Activity	• Physical activity is a strong predictor of mortality **(Evidence A)**. People with COPD should be encouraged to increase their level of physical activity although we still do not know how to best ensure the likelihood of success

Initial Pharmacological Treatment

Figure 3.7

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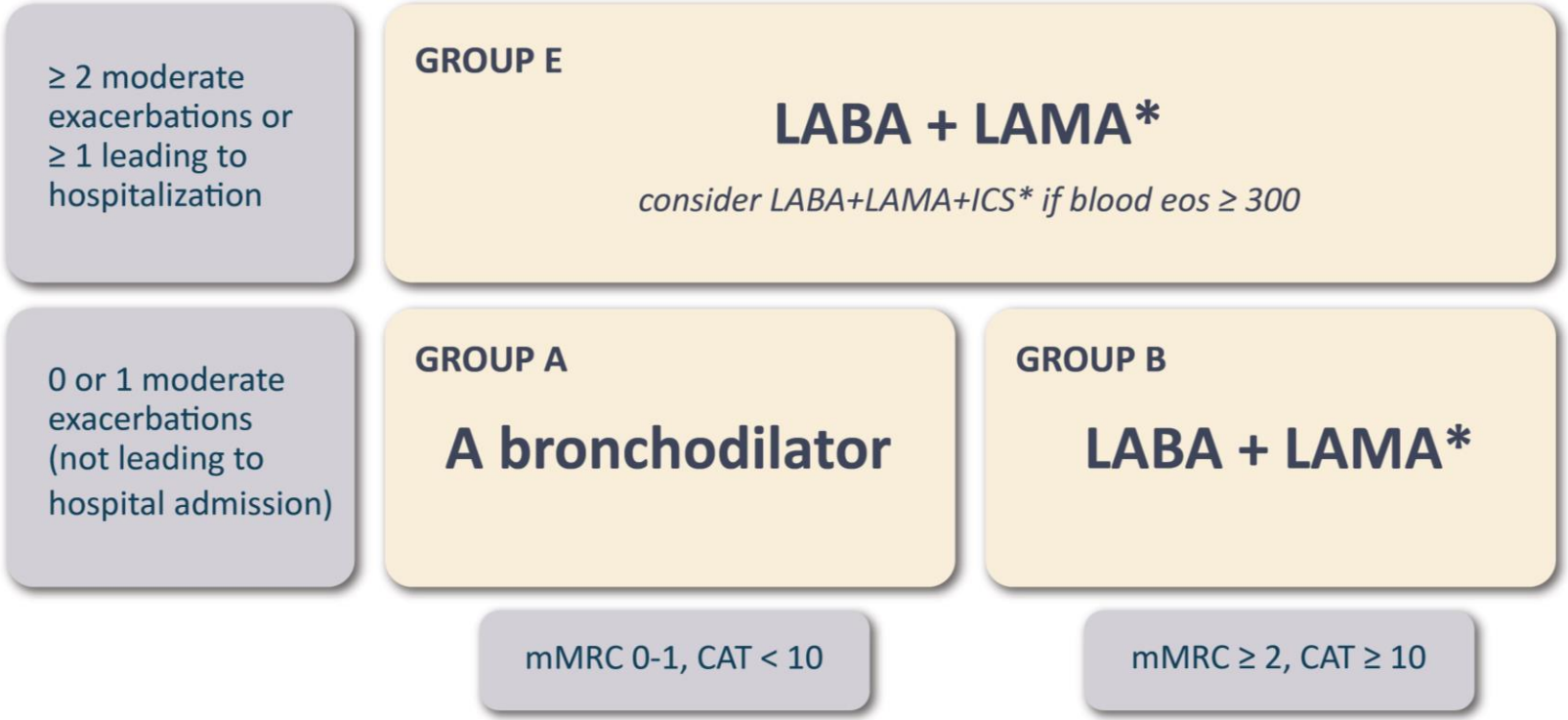

*Single inhaler therapy may be more convenient and effective than multiple inhalers; single inhalers improve adherence to treatment

Exacerbations refers to the number of exacerbations per year; eos: blood eosinophil count in cells per microliter; mMRC: modified Medical Research Council dyspnea questionnaire; CAT™: COPD Assessment Test™.

Maintenance Medications in COPD*

Figure 3.18

Generic Drug Name	Inhaler Type	Nebulizer	Oral/Injectable Delivery	Duration of Action
$BETA_2$-Agonists				
Short-acting (SABA)				
Fenoterol	MDI	✓	tablet, solution	variable
Levalbuterol	MDI	✓		variable
Salbutamol (albuterol)	MDI & DPI	✓	syrup, tablet	variable
Terbutaline	DPI		tablet	variable
Long-acting (LABA)				
Arformoterol		✓		12 hours
Formoterol	DPI	✓		12 hours
Indacaterol	DPI			24 hours
Olodaterol	SMI			24 hours
Salmeterol	MDI & DPI			12 hours
Anticholinergics				
Short-acting (SAMA)				
Ipratropium bromide	MDI	✓		6-8 hours
Oxitropium bromide	MDI	✓		7-9 hours
Long-acting (LAMA)				
Aclidinium bromide	DPI			12 hours
Glycopyrronium bromide	DPI		solution	variable
Tiotropium	DPI, SMI, MDI			24 hours
Umeclidinium	DPI			24 hours
Glycopyrronium		✓		12 hours
Revefenacin		✓		24 hours
Combination Short-Acting $Beta_2$-Agonist Plus Anticholinergic in One Device (SABA+SAMA)				
Fenoterol/ipratropium	SMI	✓		6-8 hours
Salbutamol/ipratropium	SMI, MDI	✓		variable
Combination Long-Acting $Beta_2$-Agonist Plus Anticholinergic in One Device (LABA+LAMA)				
Formoterol/aclidinium	DPI			12 hours
Formoterol/glycopyrronium	MDI			12 hours
Indacaterol/glycopyrronium	DPI			12-24 hours
Vilanterol/umeclidinium	DPI			24 hours
Olodaterol/tiotropium	SMI			24 hours
Methylxanthines				
Aminophylline			solution, injectable	variable
Theophylline (SR)			tablet, capsule, elixir, solution, injectable	variable
Combination of Long-Acting $Beta_2$-Agonist Plus Corticosteroid in One Device (LABA+ICS)				
Formoterol/beclometasone	MDI, DPI			12 hours
Formoterol/budesonide	MDI, DPI			12 hours
Formoterol/mometasone	MDI			12 hours
Salmeterol/fluticasone propionate	MDI, DPI			12 hours
Vilanterol/fluticasone furoate	DPI			24 hours
Triple Combination in One Device (LABA+LAMA+ICS)				
Fluticasone/umeclidinium/vilanterol	DPI			24 hours
Beclometasone/formoterol/glycopyrronium	MDI, DPI			12 hours
Budesonide/formoterol/glycopyrrolate	MDI			12 hours
Phosphodiesterase-3 and/or -4 Inhibitors				
Roflumilast			tablet	24 hours
Ensifentrine		✓		12 hours
Mucolytic Agents				
Erdosteine			capsule, suspension	12 hours
Carbocysteine†			capsule, packet, solution,syrup	6-8 hours
N-acetylcysteine†		✓	solution, tablet	2-6 hours
Biologics				
Dupilumab			injectable	2 weeks

*This list is not exhaustive. Not all formulations are available in all countries. In some countries other formulations and dosages may be available. †Dosing regimens are under discussion. MDI = metered dose inhaler; DPI = dry powder inhaler; SMI = soft mist inhaler. Note that glycopyrrolate & glycopyrronium are the same compound.

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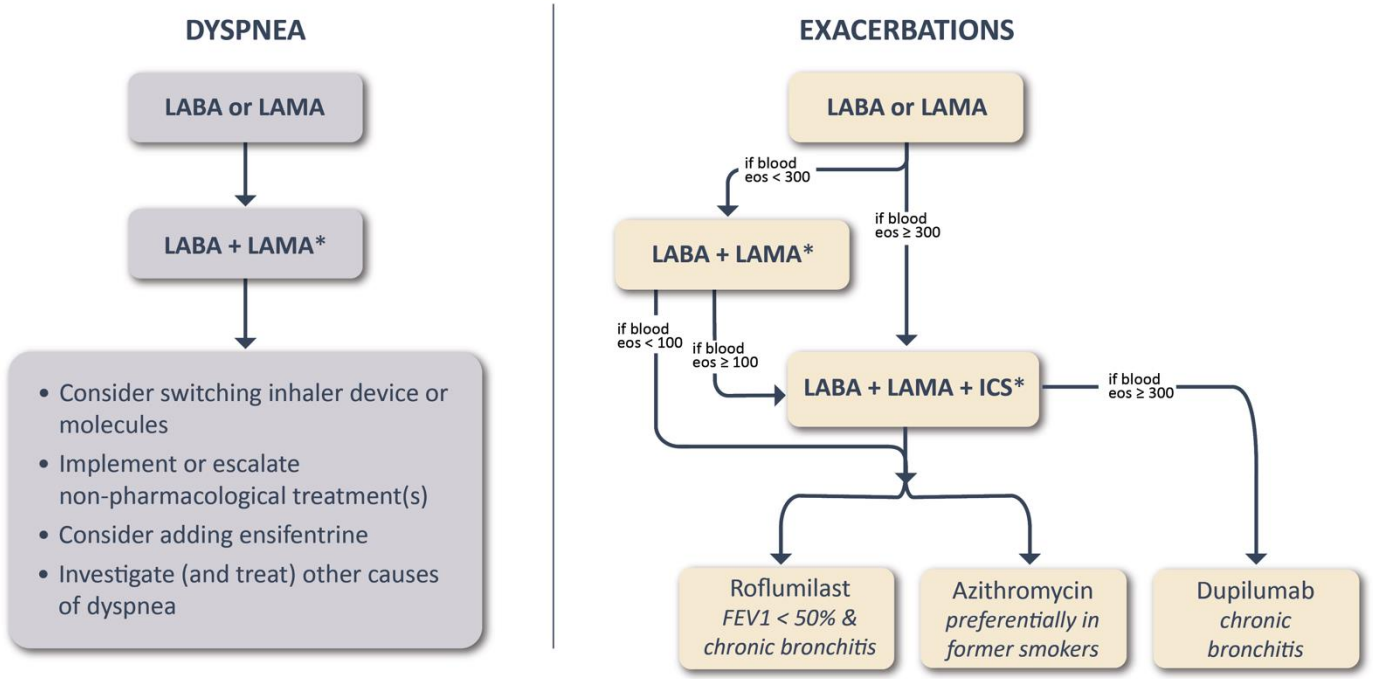
Follow-up Pharmacological Treatment

Figure 3.9



*Single inhaler therapy may be more convenient and effective than multiple inhalers; single inhalers improve adherence to treatment.

Consider de-escalation of ICS if pneumonia or other considerable side-effects. In case of blood eos ≥ 300 cells/µl de-escalation is more likely to be associated with the development of exacerbations.

Exacerbations refers to the number of exacerbations per year.

Inhaled Corticosteroids

- Regular treatment increases risk of pneumonia
- LABA + ICS not favored
- LABA + LAMA + ICS superior
  - Improved lung function
  - Improved symptoms and health status
  - Reduced exacerbations
- Always use ICS if patient has features of asthma

Factors to Consider when Initiating ICS Treatment

Figure 3.21

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Factors to consider when adding ICS to long-acting bronchodilators:

(note the scenario is different when considering ICS withdrawal)

STRONGLY FAVORS USE	History of hospitalization(s) for exacerbations of COPD[#]
	≥ 2 moderate exacerbations of COPD per year[#]
	Blood eosinophils ≥ 300 cells/µL
	History of, or concomitant asthma
FAVORS USE	1 moderate exacerbation of COPD per year[#]
	Blood eosinophils 100 to < 300 cells/µL
AGAINST USE	Repeated pneumonia events
	Blood eosinophils < 100 cells/µL
	History of mycobacterial infection

[#]despite appropriate long-acting bronchodilator maintenance therapy (see Figures 3.7 & 3.18 for recommendations); *note that blood eosinophils should be seen as a continuum; quoted values represent approximate cut-points; eosinophil counts are likely to fluctuate.

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Antibiotics

- Long-term azithromycin and erythromycin reduce exacerbations
- Azithromycin preferred
- Azithromycin associated with increased incidence of bacterial resistance and hearing impairment

Other Agents

- Long-term use of oral glucocorticoids not recommended
- Statin therapy not recommended for prevention of exacerbations
- Leukotriene modifiers have not been tested adequately in patients with COPD

Questions