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### Keys to Detecting COPD in the Primary Care Setting

Announcer:

You're listening to CME on ReachMD. This activity, titled, "Keys to Detecting COPD in the Primary Care Setting," is brought to you by The France Foundation along with the COPD Foundation and is supported by an educational grant from GlaxoSmithKline.

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Here's your host, Dr. Jennifer Caudle.

Dr. Caudle:

Even though COPD is a common lung disease, it's frequently underdiagnosed, particularly in its early stages. In fact, it's estimated that as many as 12 million Americans remain undiagnosed. And since the majority of COPD cases are first seen in the primary care office, how can we, as primary care physicians, ensure that we're not missing this diagnosis?

Welcome to CME on ReachMD. I'm your host, Dr. Jennifer Caudle, and I'd like to welcome Dr. Barbara Yawn, Dr. Byron Thomashow, and Mr. Doug Martin to the program. Dr. Yawn is the Chief Science Officer of the COPD Foundation and a primary care physician at the University of Minnesota. Dr. Thomashow is a pulmonologist at Columbia University Medical Center, and he serves as a Chief Medical Officer of the COPD Foundation. And finally, Mr. Martin is a patient with COPD who is part of the COPD Foundation's State Captains Program. Welcome to you all.

Dr. Yawn:

Thank you for having us.

Mr. Martin:

Thanks for having us.

Dr. Thomashow:

Thanks for inviting us.

Dr. Caudle:

Absolutely. Well, I'm excited that you guys are all joining us on this program. How about we start with you, Doug? How and when were you first diagnosed with COPD?

Mr. Martin:

I had chronic bronchitis several years in a row, and I finally had enough of it and asked my primary doctor what we could do to find out what was causing this, and he sent me to a pulmonologist, which had diagnosed me with COPD caused by emphysema, and that's when I first found out what was going on with it. I feel that my primary doctor had known about it for a year or longer that there was something wrong and just never sent me anywhere.

Dr. Thomashow:

Doug, I know this can be a little scary, to be provided with this diagnosis. What do you wish you had been told at the time that you were diagnosed?

Mr. Martin:

I wish I would have been told that I could learn to manage my disease and live with the disease. But now I'm doing very well as far as managing it, but at first I just thought it was a death sentence. I didn't even know I could manage it. I didn't know there was life after being diagnosed with it, but I have learned that there is, and I am living proof of it right now.

Dr. Caudle:

You know, now, according to the COPD National Action Plan, 16 million people have been diagnosed with COPD, and millions of others don't even realize that they may have it. So, with that being said, Dr. Yawn, let's go to you. Are patients with COPD being missed in primary care?

Dr. Yawn:

They certainly are. Unfortunately, as you said, there are about 16 million people with the diagnosis. The unfortunate part is there's maybe up to another 16 million that have COPD and haven't been recognized. For example, we have more people in rural areas than urban areas, and maybe it's access to care problems. Twenty-five percent of the people with COPD have never smoked, and that may not be recognized. There are more women now than men being diagnosed, and that may be something people are not recognizing. You need to think about this in women as well as men.

And then we as physicians and other clinicians may be asking really very general questions. We need to think about can we ask more specific questions about, "Are you able to do all of your usual activities?" "Are you having to change any activities because of shortness of breath?" "Are you having problems with cough or shortness of breath?" And one of the things that I think is real important is to look for people like Doug who have recurrent episodes of 2 or 3 bad colds a year, that they end up coming in and they are still having symptoms 2 weeks later. So, all of those lead to probably failure to recognize that this is a chronic condition, a chronic respiratory problem and needs evaluation.

Dr. Caudle:

And now that we know that COPD is often underdiagnosed, Dr. Yawn, what are the diagnostic pearls for recognizing it?

Dr. Yawn:

Well, as I said, really asking a specific question, making sure that people who have had recurrent respiratory events, we think beyond just treating what they came in for today, I think that's very important.

Dr. Thomashow:

I want to stress that I agree completely with what Barbara said. The questions are really important because symptoms are so often ignored or self-diagnosed or self-treated by the patients. Often times, even if they—in the short amount of time that you may have with your primary care providers, if they ask how the breathing is, the patient often says it's not bad because they have cut back on their activity level. It's very important that we make an early diagnosis because we can then earlier intervene, and we do have options of therapy, as Doug says, that can make a difference. It's really important because the diagnosis is still made with a breathing test called spirometry, and the recommendations from the Preventative Services Task Force for years have stressed that spirometry is only indicated if there are symptoms as well as risk factors, like smoking, for example, so it's really important that we ask the right questions in order to push this forward and get the testing that we need.

Doug, did you have spirometry, and did they do bronchodilator testing, which is really important, to try to define this diagnosis?

Mr. Martin:

When I was first diagnosed with it, no, but my second visit to the pulmonologist is when I took both tests and learned about the test. In fact, I'm still learning about the test, because for a layman like me, they're really hard to understand what exactly the tests are all about, but, yes, I have had both tests.

Dr. Thomashow:

Well, so that makes you unusual, actually, Doug, because most people with COPD in this country are diagnosed without spirometry, which leads, I'm afraid, to both under and overdiagnosis, so it is important to move forward with it. And as you said, it's a relatively simple breathing test. Unfortunately, attempts to get spirometry done routinely in primary care have generally not been successful. It's one of the reasons that Barbara and I and others have been involved now for over 10 years trying to move the field forward by developing a somewhat different approach, an approach based upon a simple questionnaire and peak flow testing to decide who might be better off in getting spirometry.

Barbara, I know you've been a major force in this program called CAPTURE. Maybe you might comment about it.

Dr. Yawn:

Thanks, Byron. CAPTURE is really an important recognition that in primary care it is very helpful to have some very specific questions that we can ask. These questions can be asked in the waiting room, for example. The patient can fill out the form before we see them or when they are sitting in the exam room waiting for us to come in, but 5 simple questions that really identify people who appear to be at high risk of COPD or other chronic respiratory problems, and then we can go that next step and do the spirometry. With this new tool, we may be able to make sure we know exactly who we're concerned about and who's truly at high risk.

Dr. Caudle:

Excellent. For those of you who are just tuning in, this is CME on ReachMD. I am your host, Dr. Jennifer Caudle, and I have the pleasure of speaking with Dr. Barbara Yawn, Dr. Byron Thomashow, and Mr. Doug Martin, who is a patient with COPD, about how we can get better at diagnosing and managing this common lung disease in the primary care setting.

Now, earlier we heard some staggering statistics about just how common and unfortunately underdiagnosed COPD is. And just to dive into this issue further, Dr. Yawn, can you tell us how comorbidities complicate the diagnosis of COPD?

Dr. Yawn:

I certainly can. Most people with COPD, as you heard, are smokers, about 75%. The other 25% have had common exposures to other things that are irritating to the lungs and, perhaps, to the heart and other systems. So, people with COPD tend to have multiple morbidities. They have diabetes. They have cardiovascular disease. Depression and anxiety are extremely common in people with COPD, and then things like osteoporosis. And frequently, men will have osteoporosis.

Doug, has that been a problem for you? And how was that discovered?

Mr. Martin:

Well, it was. I work construction, and I lifted something a little too heavy and cracked my back, and when I was diagnosed with the crack is when they found out that I had osteoporosis. My management of COPD is actually a 2-edged sword. It actually contributes to my osteoporosis, but yet, if I don't take it, I can't breathe so.

Dr. Yawn:

I'm sure, Doug, you're referring to the fact that you use inhaled corticosteroids every day, and we know that does increase the risk of osteoporosis, but it's important to realize, even without the inhaled corticosteroids, osteoporosis along with all of the others I mentioned are common comorbidities, and when we get the COPD diagnosed and got that first stabilization going, it's time to make sure we evaluate for those other comorbidities, and they may even be important in selecting appropriate therapy for the COPD.

Dr. Thomashow:

The only point I would stress there, Barbara, and I think you'd agree, is that you can't treat COPD by just treating the COPD. You have to treat the person who has the COPD.

Dr. Yawn:

Absolutely. For example, if someone has depression and anxiety, if you do not recognize this and treat those in the context of the whole person. People with depression tend to have trouble taking medications once or twice a day every day if you don't treat the whole person, you're not going to get the COPD stabilized and managed, as Doug says he's been able to do now to get optimal outcomes.

Dr. Caudle:

You know, now there's also this unfortunate perception out there that people with COPD are too sick, which may lead some providers to believe that there may be little to offer them in terms of treatment. So, Dr. Thomashow, let's go to you, and tell us—can you tell us maybe a little bit about how you might respond to this?

Dr. Thomashow:

Unfortunately, that perception has been one that we've been fighting for a very long time. I think it's absolutely critical for everyone to understand that COPD, as much of an impact as it has, is almost always preventable and almost always treatable. We may not have cures yet—hopefully someday we will—but we certainly have therapies that can make a difference, that can improve quality of lives, that can improve lung function, that can improve what people can do with their lives and their level of function. Yes, we have medications, and I know we're going to talk a little bit about that, but we also have exercise programs, pulmonary rehabilitation. There are clearly things that we have to offer.

One of the major issues that has led to this perception as well is the concept of blame. Many people feel that they caused it themselves with their cigarette smoking. Many family members blame their loved ones for it, that's really unfair. As Barbara has mentioned, 25% of

people with COPD in this country never smoked at all, and probably only 20–25% of smokers develop significant COPD. It's important to understand that this is a treatable disease and that we have options that we can move forward with, and some of that perception needs to be put behind us.

Dr. Caudle:

And before this program comes to a close, I'd like to hear each of your recommendations on how primary care physicians can better educate patients about their COPD and help them become actively involved in their disease management. So, why don't we start with you, Dr. Yawn?

Dr. Yawn:

Sure. I think that we need to look around and find some resources for our patients. We can't do it all in our office. We don't have time. But there are things like Better Breathers Clubs, and those are really very helpful. The COPD Foundation has an app that you can download for free that is on the Apple App Store and Google Play. It gives a lot of information. And we're releasing a patient version of this app, and it has all kinds of things there like how to take your inhalers, how to monitor your symptoms, and exercise videos, things you can do. Also, the COPD Foundation has something called 360 Social that you can get on to and talk to other people with COPD. I really encourage us to find those resources and refer patients to those resources.

Dr. Thomashow:

I think that everything you've outlined, Barbara, are the things that I tend to do. I think we are very excited about the app, especially with the new patient portal to it, and 360 Social is really important. We now have over 43,000 people from 130 different countries from around the world. This is not just a problem in the United States, guys. This is a worldwide problem. And I do think that some of the information that comes across in 360 Social is really important.

Dr. Yawn:

So, Doug, how about you? What things are you doing that you think are helpful that others might do?

Mr. Martin:

Well, I think there are 3 main things that a patient can do. One is they have to have a very good family to help them. They have to have a good background, someone that will look up information if they're like me and don't get on the computer a lot. And another thing is they need to exercise. A person that exercises is going to keep the muscles around their lungs very loose and be able to breathe easier. It won't take as much energy for them to breathe if they keep their muscles active. Another thing is they need to join social groups. My social group is Harmonicas for Health, which is put on by the COPD Foundation. I'm actually a teacher of 3 classes. And the last thing I think that patients really need to know is that your lungs are like a car engine. The better you treat them, even after you have the disease, the better they're going to work for you with the disease.

Dr. Yawn:

I think that's so important, and I do want to stress that Harmonicas for Health—I'm excited that you're a teacher. This is a fun way to do activity, because we all know, "Yeah, let's go out and exercise," that doesn't sound so interesting, but if you can, as you said, do activities with friends, with family, do something fun like learn to play the harmonica, that's the way that we want to help people, to integrate activities, socialization, and COPD care into their life.

Dr. Caudle:

And, you know, I really couldn't think of a better way or a thought to leave our audience with than that. So, I'd really like to thank my guests, Dr. Yawn, Dr. Thomashow and Mr. Martin. You guys were excellent, and I just want to thank you each for sharing your unique perspectives on how we can get better at diagnosing and managing COPD in the primary care setting. Thank you, everyone, for joining the program today.

Mr. Martin:

Thanks for having me.

Dr. Thomashow:

Thank you, guys.

Dr. Caudle:

Thank you.

Announcer:

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