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What's New in COPD Care: Updates to the GOLD Guidelines & Other Advances

Announcer:

You're listening to *Deep Breaths: Updates from CHEST* on ReachMD. This series is produced in partnership with the American College of CHEST Physicians. The following episode was recorded live at the 2019 annual CHEST conference in New Orleans.

Now, here is host Nic Hanania.

Dr. Hanania:

Hello. I'm your host for this discussion, Dr. Nic Hanania. I'm Associate Professor of Pulmonary Critical Care Medicine, and Director of the Airways Clinical Research Center at Baylor College of Medicine in Houston, Texas. And joining me to discuss the advances in diagnosis and treatment of COPD that were presented at the 2019 annual CHEST meeting is Dr. Neil Freedman. Dr. Freedman is the Division Head of Pulmonary Critical Care Allergy and Immunology at North Shore University Health System in Evanston, Illinois. Dr. Freedman, it's great to have you, uh, here today. And I think our colleagues will really enjoy listening to our conversation.

Dr. Freedman:

Well, Nic, thank you, uh, for inviting me to participate. I'm looking forward to our conversation, as well.

Dr. Hanania:

Great. So, let's just dive right into this topic, Neil. What advances in the diagnosis and treatment of COPD have been discussed in this year's CHEST conference?

Dr. Freedman:

Uh, well, Nic, actually there are quite a bit, uh, of discussion and lots of sessions. Specifically, there are several sessions on approaches to reducing admissions and readmissions for patients with COPD, including a session that I was privileged to be a part of, uh, with several experts from both the United States and Canada. We had a couple of sessions on the appropriate use of noninvasive ventilation in patients with chronic respiratory failure and COPD. Uh, there were a couple of sessions on the role of, uh, the use of peak inspiratory flow rate for determining the most appropriate inhaler therapy for a given patient. A session on female gender and the burden of COPD. Uh, a session on the pharmacologic uncertainties that still face us, uh, when we're treating our patients with COPD. Uh, and then finally there were some recent data published, uh, in *The New England Journal of Medicine*, an article on the role of beta blockers and reducing the risk of exacerbations and death in patients with moderate to severe COPD. Interestingly, in this randomized controlled trial, the use of beta blockers among patients with COPD who didn't have an indication for

this medication class, uh, beta blockers did not reduce, uh, the risk of first exacerbation, and actually it was associated with more frequent hospitalizations. I don't know, Nic. Anything else from your experience at the meeting that I missed?

Dr. Hanania:

Yeah, no, I think it's great that you summarized all of this in a just short period of time. I think we learned, and continue to learn, a lot of about, you know, diagnostic, uh, approaches. And in fact, there are some new data emerging about the use of, uh, radiologic biomarker and imaging in the – in the subtyping of COPD. You know, as you know, Neil, for many years we looked at this disease as a one-face – it's, uh, a one-face disease, and we approached it – and we'll talk about treatment in a few minutes, but we approach it as – as one disease, but in fact there are multiple phenotypes. And I think the more biomarkers you have, including radiologic biomarkers – I was impressed with some data that was presented on radiologic biomarkers and CT scan imaging, uh, and subtyping these patients. Of course clinically, as clinicians me and you, we see these patients come in and they don't look the same; not only feature-wise, but symptom-wise. You don't respond the same to treatments, so I think one has to be thinking outside the box. And in some of these presentations, we highlighted the need for us to do so now in the year 2019. So, as I understand, Neil, a significant update, uh, um, that comes from the GOLD strategy in 2019, and some of which were presented at CHEST. What can you tell us about that?

Dr. Freedman:

Uh, actually in many of the sessions the updated GOLD strategy recommendations, uh, were discussed. And as you know, uh, there's even a 2020 version that should be coming out shortly. Uh, but some of the highlights included the appropriate use of pharmacologic therapy. Uh, and as you recently discussed, you know, adjusting therapy based on symptoms and exacerbation, uh, appropriate use of noninvasive ventilation, and even a section on self-management and behavioral changes that's been added to some of the more recent GOLD strategies. Um, there's the newest version of the GOLD strategies are actually focusing more on how to personalize therapy based on several factors, as you had discussed, including, you know, phenotypes and – and not treating it as, um, uh, the same therapy for everybody, but actually up-titrating and down – down-titrating, uh, pharmacologic interventions based on symptoms exacerbations and where patients fall along the spectrum of their disease.

Dr. Hanania:

Yeah. And you know, some of the – some of the things that came up from GOLD are still controversial. I hope you agree. But, the use of biomarker was mentioned in those radiological biomarker, but you know, when it comes to, for example, use of blood eosinophil and the cut-off they recommend using to justify using inhaled corticosteroids, for example, is still up in the air. There are lots of – I don't know what your take on this, if you have any. Should we be using blood eosinophils in managing these severe patients? And are they going to tell us anything about adding treatments like inhaled steroids? Um, that's still a question out there. Um, um, the GOLD committee, obviously they are not guidelines they suggest we do in someone with, uh, blood eos more than 200, and with exacerbation, they – they definitely recommend inhaled corticosteroid agent on board. While someone with blood eos less than 100, they recommend not to use inhaled steroid in these patients. It's also interesting that GOLD now is really emphasizing something that we missed for a long time is the delivery systems, you know. And were you impressed with anything at – at the CHEST meeting about the inhaled delivery? And you mentioned PIFR, or PIFR, or peak inspiratory flow rate, and were there any data to suggest that that's important in selecting the delivery system?

Dr. Freedman:

Well, uh, that's a great – I guess that the real question is – is does – or picking an inhaled medication and the device, uh, does it really change meaningful outcomes? And, you know, whether that admissions, readmissions, exacerbations, you know, based on the literature that's out there specifically looking at the use of peak inspiratory flow rate, uh, in this disease, it's not really clear yet that, uh, using peak inspiratory flow rate changes those meaningful outcomes. Theoretically, it makes a lot of sense to me, uh, in that we probably should be thinking about how to modify our certain types of therapy based on what's happening with changes in their physiology during an acute exacerbation. I just don't know that we have a lot of data to support that.

Dr. Hanania:

Hmm. Thanks, Neil. For those just joining us, this is ReachMD. I'm Dr. Nic Hanania, and today I'm speaking with Dr. Neil Freedman about the latest updates on COPD that were presented at the 2019 annual CHEST meeting in New Orleans. So, Neil, let's carry on and discuss – we discussed nicely about some of the advances that were covered at CHEST 2019. I'd like to turn our attention to the treatment. I know you started discussing, uh, treatment and exacerbation. As you know, Neil, COPD exacerbation continues to haunt many of our patients, and of course us in the healthcare system. Were there any treatments strategies in managing exacerbation that were, uh, discussed at CHEST that you want to bring up?

Dr. Freedman:

Uh, yes. Some of the strategies are – are common sense strategies, so you know, the first – and we discussed this a little bit, um, today. You know, the first is just to better manage patients at baseline to avoid exacerbations in the first place. And this, in part, could be achieved by following the recommendations of the updated GOLD strategies. Uh, we actually had a, uh, great session, uh, that was myself, John Bourbeau, Valerie Press, uh, that was a, uh, panel discussion specifically focused on reducing admissions and readmissions. We spent a lot of time emphasizing, you know, proper inhaler choice, and especially, uh, re-educating patients over and over again on the appropriate, uh, use of, uh, inhalers and inhaler techniques. Uh, we, you know, we talked a little bit about peak inspiratory flow rate, which you and I discussed earlier, uh, today. And we also talked a little bit about the role of phenotyping to try to determine the best personal therapy for a given patient. But I think at the end of the day, you know, if we can identify more patients by the use of spirometry and really, you know, follow the – the guideline-based therapy and – and educate our patients over and over again about how to use their inhalers appropriately, I think that would go a long way to improving meaningful outcome.

Dr. Hanania:

Yeah, absolutely. And I think of course one thinks about managing exacerbation or just think about medication, there are so many other things, including, you know, the inhaler devices, the education piece that sometimes we miss even though it doesn't cost too much. Uh, and of course the delivery system that you mentioned. We also discussed at the CHEST meeting the role of bronchodilators, as you know it's emerging now. We have tons of bronchodilators out there with different combination. I think those are very effective, but alone they don't do too much without the other interventions that you mentioned. Well, you know, there is some trend now to look at personalized treatable traits. Uh, it's not just the phenotypes, but also how the patient's symptoms are and – and, uh, comorbidities, which are very important. Uh, any takes on this, uh, from the conference?

Dr. Freedman:

Yeah. Uh, again, I think some of the stuff we've already covered, but I think, you know, for patients with a current exacerbation or hospitalization, and those with what has been eosinophilic or asthmatic phenotype, I do think there is a role for the inhaled steroid or triple therapy in these individuals, but I do like the fact that the newer, uh, GOLD strategy recommendations, they really limit the use of inhaled steroids to specific subgroups of individuals. Uh, I think there may be a role for some biologics somewhere down the road, although that's, uh, I still don't know that we have enough data to – to clearly support the use of biologics in these individuals.

Dr. Hanania:

Yeah, and I agree with you. Yeah. I agree. Right now, we're not really – you know, we've done some good advances in severe asthma, but in COPD so far, nothing really is promising. But hopefully we'll have some more treatments for these patients, especially those with very severe COPD. But, you know, from the personalized approach, I think one has to keep an eye on our comorbidities. We – I shared a session on psychologic comorbidities of COPD at CHEST, and we discussed depression, anxiety, and us as pulmonologists, we sometimes forget about it, and it's very important. But of course, other comorbidities are important to keep in mind. Well, unfortunately, Neil, we're running out of time. But before we go, uh, if you could give one call to action to our colleagues who are listening about diagnosis and treatment of patients with COPD, what would that be?

Dr. Freedman:

I actually, Nic, I have four. Uh, so they're all important and I can't really prioritize them. But I think one would be to educate our non-pulmonary specialists to increase the use of spirometry to diagnose patients earlier in the course of their disease. You know, two, to continue to push for tobacco cessation and further education. Uh, three, educating our patients on proper inhaler techniques to

improve symptoms and outcomes. And then finally, you know, continuing to push for additional support for pulmonary rehabilitation.

Dr. Hanania:

Well, I couldn't think of a better way to wrap our discussion today than with these great calls of action that, uh, sorry, let me repeat. Well, I couldn't think of a better way to wrap our discussion today than with, uh, with these, uh, remarks and call to action. So with that, I'd like to thank Dr. Neil Freedman for joining me to discuss emerging breakthroughs in the management of COPD. Neil, it was great speaking with you today.

Dr. Freedman:

And Nic, it was great speaking with you. And thanks for having me.

Dr. Hanania:

I'm Dr. Nic Hanania, and thanks for listening.

Announcer:

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