

Transcript Details

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Reviewing & Implementing the Latest COPD Screening Guidelines

Announcer:

Welcome to *Clinician's Roundtable* on ReachMD. This episode is brought to you by Grifols. Here's your host, Dr. Charles Turck.

Dr. Turck:

Welcome to *Clinician's Roundtable* on ReachMD. I'm Dr. Charles Turck, and joining me to take a look at the latest screening guidelines for alpha-1 antitrypsin deficiency, or AATD for short, for patients with chronic obstructive pulmonary disease, is Dr. David Mares, who specializes in Adult Pulmonology and Critical Care in Anderson, Indiana. Dr. Mares, thanks for being here today.

Dr. Mares:

Thank you for having me.

Dr. Turck:

So to start us off, Dr. Mares, what can you tell us about what different professional guidelines have to say about AATD-associated COPD?

Dr. Mares:

We have several different professional organizations that have made comments about screening for alpha-1 antitrypsin deficiency within our COPD patients. We've started from the concept in medicine that we could somehow recognize an alpha-1 patient based upon specific features of either their symptoms or their severity of disease. And I think that those sorts of guidelines are really antiquated. What we really need to focus on, and some of our guidelines today help us to do that, is screening all COPD patients for alpha-1 antitrypsin deficiency, and I'll talk about a little bit more about who else fits into that list.

But we really have studies now that show us that the symptoms that alpha-1 antitrypsin deficiency-associated COPD patients have are not different in any recognizable fashion from the symptoms that other COPD patients have and the symptoms that some of our asthma patients have. So we can't distinguish a specific feature about a person that says you should be screened where someone else with COPD or significant asthma would not be screened.

So to start out with our World Health Organization guidelines are very vague, and probably not very helpful. At least it is mentioned that COPD patients should be screened. Our COPD Foundation guidelines are actually very good and very comprehensive and suggest screening in a very open sort of fashion for all patients that have COPD, patients that have asthma that's not readily or easily controlled with a low to moderate dose medications, screening family members, and screening bronchiectasis patients. So we have a good set of guidelines within the COPD Foundation.

Our Global Obstructive Lung Disease guidelines still are a little bit restrictive and still have that flavor of suggesting that there's some way that we can define who would be more likely among the COPD population to have the disease. For example, it's suggested there that we would screen patients whose disease severity or symptom severity is out of proportion to the degree of exposures that they've experienced in their lifetime.

And thereafter the oldest of our guidelines, the American Thoracic Society and European Respiratory Society guidelines, which are 20 years old today, actually did have a very good summarization and suggested a broader screening protocol, such that we're screening everybody with COPD, everybody who has asthma that's not well controlled with standard therapies, everybody who has bronchiectasis, everybody who has emphysema, even if they don't have obstruction.

So in my opinion, my practice screening is more aggressive and more all-inclusive than really almost all of the guidelines with the

exception of the COPD Foundation. As I have screened through my history and doing this somewhere near 30 years now, I started by screening only those people that had a feature that suggested to me that it was more severe COPD, and/or out of proportion to exposures, et cetera. And now I've gone to screening literally everybody with the diagnosis of COPD, everybody with the diagnosis of asthma that does not come under control very readily with low to moderate range medications, everybody with bronchiectasis, and family members. And the reason for that is that I have discovered that if a patient walks in to see me and the first words out of my mouth and my internal thoughts are, 'Gosh, I should screen this one for alpha-1,' if I view that situation now, I'm less likely to find that patient to have alpha-1. The ones that I find are the ones that are actually not the ones that it just strikes you right away that this is somehow likely to be alpha-1.

And more importantly, as we're talking about a transition to preventative medicine, we really want to catch those people who have milder disease so we can have more of an impact on that patient's situation than somebody who comes in to see us and has really advanced COPD. Yeah, we still want to make that diagnosis in the advanced COPD patient, but much of the damage is already done. Our value to patients is when we diagnose people much more early, before the damage has completed.

Dr. Turck:

So I was going to ask how do we put all this guidance into practice and improve early recognition of AATD-associated COPD?

Dr. Mares:

We as doctors, a lot of times have more on our plate than what we have the time to remember during our busy office practices, and particularly, in the world of primary care, they have so many things they need to do in such a limited amount of time. The way to make this happen is to set up screening protocols within our own practices so that we check these patients and have the person that's checking them in accomplish the screening when they meet certain criteria.

How we have accomplished this in our office is that our office staff knows that if they have a diagnosis of COPD that their chart will be reviewed to see if they've already had an alpha-1 screening process done. If they haven't, then they will go ahead and screen them. The asthma patients are a little more up to the doctor as to which ones we're going to screen. Our pulmonary function lab, we've set it up already that when somebody comes in for pulmonary functions or pulmonary rehabilitation, they are offered screening because that allows us to catch patients that have, maybe not been severe enough to yet require a pulmonary consultation, but their primary care physician is interested in their lung function. So when they're offered screening, a lot of times that gives us the opportunity to catch that disease a little earlier. And we have had some very good early catches through our pulmonary function screening program.

And then finally, we're hoping to have all patients admitted with a COPD diagnosis and/or an asthma exacerbation diagnosis offered screening in our hospital. And that's something that's just been a little slower to gain traction.

Dr. Turck:

For those just joining us, this is *Clinician's Roundtable* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Dr. David Mares about the latest screening guidelines for COPD patients with an alpha-1 antitrypsin deficiency, or AATD.

So now that we have a better understanding of what the professional guidelines have to say, Dr. Mares, I was wondering if you would share some management strategies to help us effectively treat these patients.

Dr. Mares:

So with our patients in the office that we manage for alpha-1 antitrypsin deficiency, of course, we're looking for those that have a severe deficiency state, which is usually a ZZ genotype or an SZ genotype. And those patients are going to be initiated on augmentation therapy when appropriate, and particularly, after they have discontinued tobacco use. So augmentation therapy is a big part of that management technique. But also really anybody with an abnormal allele, a carrier state, is going to receive special focus in our office. We're going to be more aggressive than average in helping them to minimize tobacco use. We're going to be encouraging vaccinations for the hepatitis B and hepatitis A. We're going to encourage vaccinations for influenza and pneumonia to minimize the risk of liver cancer, especially, considering the hepatitis and alpha-1 and its involvement in the liver. But we're also going to minimize the risk of any oxidative stress in their lungs. Things like bacterial infections and viral infections. When the patient with alpha-1 calls in, even if they're a carrier, they're more likely to be treated aggressively with antibiotics and steroids than our average COPD patient because any of those infections are going to increase their neutrophil activity in the lungs and their oxidative stress. And so we're very aggressive with all the alpha-1 patients, including the carriers, and again, the severe deficiency state patients are going to be assessed aggressively for the possibility of augmentation therapy.

Dr. Turck:

Now before we come to a close, Dr. Mares, are there any final thoughts you'd like to leave with our audience today?

Dr. Mares:

I think that the best thing that I can suggest to all of you is that we incorporate screening to the same degree of importance in our practice as when we screen for other diseases, like diabetes, and screening for the various cancers that we screened for. Alpha-1 antitrypsin deficiency is as important in the COPD world as many of these other diseases are in their individual disease processes. So when we talk about screening for alpha-1, we can have a major impact in that COPD patient. And even if that's the last thing on your mind, that's really the patient we want to screen because if alpha-1 is having an impact in a milder COPD patient, we can have more of an impact in the early treatment of that patient. And we from a preventative care standpoint want to catch our patients as early as possible. So we want to screen those milder patients that don't yet have end-stage manifestations of disease. Of course, we still want to catch the end-stage patient because we can do a lot for them as well. But if we catch the early patient, that really matches our needs to act in a preventative way for that individual patient, hopefully, changing their disease process, changing their exposures so that they don't end up being one of those end-stage patients.

Dr. Turck:

Those are some great insights as we come to the end of today's program. And I want to thank my guest, Dr. David Mares, for sharing his perspective on the guidelines for alpha-1 antitrypsin deficiency and COPD. Dr. Mares, it was great having you on the program.

Dr. Mares:

Thank you very much. It's a pleasure to be able to hopefully impact the practice of a lot of our other docs that may not yet have a very comprehensive screening program for alpha-1 related diseases in their office. Thank you.

Announcer:

This episode of *Clinician's Roundtable* was brought to you by Grifols. For information about Alpha-1 screening or to order a free AlphaID™ screening kit to rule out Alpha-1 deficiency in your patients, visit this episode's landing page and click on the 'Click here' link to access the order form. To access this and other episodes in this series, visit [ReachMD.com/Clinicians Roundtable](https://ReachMD.com/CliniciansRoundtable), where you can Be Part of the Knowledge. Thanks for listening!