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AATD Testing for COPD: Addressing Challenges & Barriers

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:
This is *Clinician's Roundtable* on ReachMD. I'm Dr. Charles Turck, and joining me to discuss how we can overcome barriers for patients with COPD associated with alpha-1 antitrypsin deficiency, or AATD, is Dr. Brian Smith. Dr. Smith specializes in Family Medicine and Hospice and Palliative Medicine at Versailles Family Medicine in Kentucky. Dr. Smith, thanks for being here today.

Dr. Smith:
Happy to be here and spread the word about alpha-1 and COPD.

Dr. Turck:
Well, to get us started, Dr. Smith, when do you suspect that a patient with COPD has AATD?

Dr. Smith:
The classic definition or classic presentation is going to be a young person who comes to your office often healthy, a runner even, who complains that they just can't run as far as they used to without getting short of breath or an office worker going upstairs can't go upstairs as easily. And then that they also have no history of smoking. And so you think, "Well, this is kind of weird, what is causing a pulmonary disease in a young person?" And so you think, "Okay, well, alpha-1 that might be it." And so you would work on that patient up for alpha-1. But like I said, that's your textbook example that any student, first-year resident, is going to be like, 'Oh, yeah, that's pretty identifiable.' And after it's been a mystery diagnosis a couple of times a lot of patients would even be able to figure that patient out.

Dr. Turck:
And how do we currently screen for AATD in patients with COPD? What do we need to know about it?

Dr. Smith:
So the current recommendations are screening anybody with COPD, regardless of smoking history. Patients with asthma that have irreversible defect after bronchodilator therapy, and then certain patients with abnormal liver functions. And alpha-1 antitrypsin is a genetic disease, so anybody, any family member of the patient that has alpha-1 antitrypsin deficiency.

The screening test is, like I said, it's genetic, so it can be done either with a buccal swab or a blood draw, or even just a finger stick. So it's very simple to do. And we even send the buccal swabs home with patients to test their family members if their family members can't get to the office, either a rural area or an underserved area. And those test kits are free.

Dr. Turck:
Now does our current approach to AATD screening in patients with COPD have any limitations?

Dr. Smith:
I think the biggest limitation is probably two. One, the biggest would be just clinician knowledge. Classically, AAT is taught as a very rare disease in medical school and in PA and NP schools—you find one patient and you can retire because that means you've seen enough patients—however, the truth is it's very common, I wouldn't say very common, but it's very common for a rare genetic disease on the scale of, in some populations, consistent with cystic fibrosis and several other tests, and more common genetic diseases that we screen for on the newborn screen. So I think that's the number one limitation, is doctors think that we're just not going to see it in our careers.

And then, I think probably, the second limitation would be lack of penetration of guidelines. And so what I try to teach people that come

through my office, residents and students, just in any time you consider prescribing an inhaler or consider that a patient has asthma or COPD if I don't have spirometry in my office, which a lot of clinicians don't, I personally do, but if I'm practicing and I don't and I want to test somebody for COPD or asthma, then I should be testing them for alpha-1 at the same time. So basically, it's anytime you think about an inhaler, you should be thinking about and screening for alpha-1.

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. Brian Smith about screening for alpha-1 antitrypsin deficiency, or AATD, in patients with COPD.

So with the challenges we've discussed in mind, Dr. Smith, are there any strategies we can employ to better or more proactively detect AATD in patients with COPD who are likely to have it?

Dr. Smith:
Yeah, I think a couple of things. One would be aggressively testing family members of patients that have it. That's how you find the vast majority it seems like of your patients because it's, being a genetic disease, you can find one patient and then go down their family tree or up their family tree and you can find several more. So that's pretty useful. I think we've done a few community screenings. Like I said, since the test is free, you can set up a booth at a health fair or even, it's coming up, you have all those great summer fairs, and setting up a booth there to test people that have COPD. And that's pretty easy to screen for. Do you use an inhaler? Alright, let's get you tested for alpha-1. And then like I said before, any time you are prescribing an inhaler or thinking about prescribing an inhaler for a patient you should also be screening that patient for alpha-1.

Dr. Turck:
And how do we reduce the time from when patients experience symptoms to both getting a diagnosis and receiving treatment?

Dr. Smith:
I think like with most lung diseases or cancers, early screening and early detection is the key to ideal treatments. And so it's picking up that COPD patient at their first visit for shortness of breath, it's not waiting for them five years down the road and you've advanced them from single therapy to dual therapy to triple therapy, and now you're like, "Oh, maybe we should test them for alpha-1." It's testing them at the first visit at first point of contact. That way, like I said, it's a genetic disease, so it's going to show up at any time in their life. And so testing them sooner will get you the results faster. And then, at that point, you have the choice of calling your local pulmonologist or your testing rep and discussing the results, and then figuring out who needs to be referred. Or, obviously, I do a lot of alpha-1, and that's why I'm doing this interview, so it is possible and easy for primary care physicians to treat alpha-1 also. There are some guidelines for that. And if you get into that, I would suggest you look at some resources. And there's a few things that you need to do like hepatitis vaccines and smoking cessation discussion, that type of stuff. But if you're not comfortable treating alpha-1 and you want to refer to a pulmonologist, then I think that's totally reasonable also. But screening early at that first point of contact I think is critical.

Dr. Turck:
Now as we come to a close, Dr. Smith, are there any final thoughts you'd like to share with our audience today?

Dr. Smith:
I would say to recap, one, it's a much more common disease than what we were taught in medical school. It's as common, if not more common, than multiple tests on the newborn screen, which everybody in America gets.

Number two, it is a free and easy test. It's a genetic test. So it's a fingerstick, blood draw, or buccal swab.

And then number three is you can and should, and the guidelines support this, test any patient, essentially, who you're reaching in to give an inhaler to.

Dr. Turck:
Those are some really great takeaways for us to consider as we come to the end of today's program. I want to thank my guest, Dr. Brian Smith, for joining me to share his insights on alpha-1 antitrypsin deficiency testing for patients with COPD. Dr. Smith, it was great having you on the program.

Dr. Smith:
Happy to join and share the knowledge and the interest in alpha-1.

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

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