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COPD Care Redefined: A Review of the Updated GOLD Treatment Recommendations

Dr. Wilner:
The Global Initiative for Chronic Obstructive Lung Disease, also known as GOLD, has updated some of the recommendations for diagnosing and treating patients with COPD. These changes have direct impacts on the treatment of patients with COPD in clinical practice.

Welcome to *Clinician's Roundtable* on ReachMD. I'm your host, Dr. Andrew Wilner. Joining me today to discuss these updates and recommendations is Dr. Neil Skolnik. Dr. Skolnik is a Professor of Family and Community Medicine at the Sidney Kimmel Medical College of Thomas Jefferson University and Associate Director of the Family Medicine Residency Program at Abington Jefferson Health.

Dr. Skolnik, thanks for joining me today.

Dr. Skolnik:
Andrew, it is an absolute pleasure to be here.

Dr. Wilner:
So let's jump right in, Dr. Skolnik. Please explain the key updates in the 2023 GOLD guidelines for COPD management.

Dr. Skolnik:
Andrew, the GOLD guidelines have been around for a long time. This is one of the major updates. Now there are two large conceptual changes that occurred in this update. One is an increased emphasis on exacerbations, and the other is looking at COPD mortality as an important goal—that is to decrease COPD mortality—because now we have medicines that do that. Let's talk about how those conceptual changes actually play out. And the most important way they play out is in the algorithm for categorizing COPD, which leads to our decisions about treatment.

Our listeners will recall that the previous algorithm was these four quadrants labeled conveniently A, B, C, and D. And on the bottom part of that four quadrant, that large square, A and B are people who are not having a lot of exacerbations. As we go from the left to the right, A to B, they have increasing levels of symptoms. On the Y axis, essentially, as you go up, A and B doesn't have exacerbations but has increasing levels of symptoms. When we used to get to C and D, that denoted people who had exacerbations, specifically two or more moderate exacerbations or one or more severe exacerbations—a severe exacerbation being someone who lands in the hospital needing IV steroids, antibiotics, and oxygen, of course.

Because the current guidelines have sought to emphasize that our treatment is particularly effective for exacerbations and the idea of preventing future exacerbations is critical, they said, "Let's get rid of subcategorizing C and D. Let's make C and D, the top part of that quadrant, into a new category that subsumes both called E." E stands for exacerbations.

So the reason they did that was so that we really don't stand a chance of missing exacerbations.

Dr. Wilner:
Is there a linear relationship between the number of exacerbations you have and your outcome? In other words, more exacerbations and then leading to death, is that what happens?

Dr. Skolnik:
That is the perfect question, so that allows us to talk about why exacerbations are important. It's not linear. I'll say that from the start. But there's a clear relationship between exacerbations and severity of exacerbations and outcomes. And why do we care about

exacerbations? A number of reasons. One, kind of obvious to everyone who has COPD, they make you feel lousy. Right? You have an exacerbation, and it interferes with your quality of life. The other reason is that exacerbations, in addition to having a short-term, very quick diminution of airflow, leads to a decreased airflow long term, so you lose lung function, essentially, every time you have an exacerbation. And then what happens is it sets you up for future exacerbations. The best predictor, Andrew, of a future exacerbation is a past exacerbation, so with each exacerbation, you are more likely to have more, and they are more and more likely to occur at shorter and shorter intervals, so we want to prevent repeated exacerbations.

Dr. Wilner:
For those just tuning in, you're listening to *Clinician's Roundtable* on ReachMD. I'm Dr. Andrew Wilner, and I'm speaking with Dr. Neil Skolnik about the latest updates from the Global Initiative for Chronic Obstructive Lung Disease on the management of patients with COPD.

So is there anything that a primary care physician can do besides the usual stop smoking, exercise? Is there anything special that you can do to sort of change that curve?

Dr. Skolnik:
Not surprisingly, Andrew, there is, and I am so glad you mentioned exercise and stopping smoking because that is foundational and critical. We could even use a fancy term like "pulmonary rehab" for what you and I call "exercise." Pulmonary rehab has a strong evidence base to show that it's effective at improving quality of life and improving outcomes. Stopping smoking is the other critical thing because there is nothing worse for your lungs than cigarette smoke, so again, that is an important part of emphasis.

But now, unlike when you and I trained a few years ago when there was this sense of futility around COPD—there weren't medicines available that did a lot—we live in a different world now, and there's a lot we can do about COPD that allows us to both decrease exacerbations and actually decrease mortality, which used to be the holy grail of research in COPD. There are a number of trials—the TORCH trial is the most memorable one—where we wanted to see if our interventions could decrease mortality. The TORCH trial just missed its P value for that. That was, I believe, fluticasone and salmeterol, versus placebo.

But now we have actually, Andrew, two trials: the IMPACT trial and the ETHOS trial. Both trials, both of which lasted a year, had almost a 50 percent decrease in mortality when comparing triple therapy—that's inhaled corticosteroids, ICS, along with a LAMA and a LABA—compared to dual bronchodilator therapy. Both trials using different ICS/LABA/LAMA combinations showed that you could have substantial decrease in mortality when treating people who have exacerbations. That has led to important changes in the guidelines that say, yes, there is something we can do if people are having exacerbations both to decrease the likelihood of future exacerbations and to likely—and these weren't primary endpoints, that's why I'm using the qualifier "likely"—decrease mortality. And the main thing to recognize here is really when to advance to triple therapy.

Dr. Wilner:
And do the guidelines tell us that?

Dr. Skolnik:
They sure do. So initial treatment of people who are having exacerbations defined, as I mentioned earlier, is dual bronchodilator therapy. Now what the guidelines say with that initial therapy, if someone has greater than 300 eosinophils; that's another relatively new thing over the last few years because we know that inhaled corticosteroids, ICS, works more predictably in people with higher levels of eosinophils on a regular old routine CBC with diff beginning at a level of about 100 eosinophils. Three hundred is the other cutoff. So if you have less than 100 eosinophils, it's unlikely that your ICS is going to do a lot, but it does increase the risk of pneumonia in older people. But as you get to higher levels from 100 to 300 and above, there's an increasing likelihood that inhaled corticosteroids will be effective at decreasing future exacerbations. So what the guidelines now say, initial treatment for people in group E is dual bronchodilator therapy. That's a LABA, long-acting beta agonist, and a LAMA, long-acting muscarinic antagonist. Now if you're at high risk of exacerbations—that's that group B—and you have blood eosinophils greater than 300 even initially, go straight to triple therapy: an ICS, LABA, and a LAMA. Now in follow-up, if you have eosinophils greater than 100, so a lower cutoff, if you were on dual bronchodilator therapy and then you have an exacerbation—and by far, Andrew, the majority of people with COPD have eosinophils greater than 100—if you do and you've had an exacerbation on dual bronchodilator therapy, now move to triple therapy. And there's even data out there. There are very interesting real-world studies that show after a hospital admission for COPD, every month delay in initiating triple therapy leads to about an 11 percent increase in the likelihood of an exacerbation.

Dr. Wilner:
Dr. Skolnik, I want to thank you for that very clear explanation. And we've covered a lot today, but before we close, are there any additional thoughts you'd like to leave with our audience?

Dr. Skolnik:
Sure. I think the main thought is that recognize that there's something that you can do now to help our patients with COPD. This is not medicine here like it used to be even just a decade ago. There is therapy, both dual bronchodilator therapy and triple therapy, that have robust replicate studies that show that the correct treatment yields important benefits.

Dr. Wilner:
Well, this was a very important discussion on the updates from GOLD regarding COPD diagnosis and management. And I want to thank my guest, Dr. Neil Skolnik, for sharing his valuable insights.

Dr. Skolnik, it was a pleasure speaking with you.

Dr. Skolnik:
Andrew, it was a pleasure speaking with you as well.

Dr. Wilner:
For ReachMD, I'm Dr. Andrew Wilner. To access this and other episodes in this series, visit *Clinician's Roundtable* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening.