

Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: <https://reachmd.com/programs/clinicians-roundtable/missed-misdiagnosed-copd-cases/54199/>

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Addressing Missed and Misdiagnosed COPD Cases

Announcer:

You're listening to *Clinician's Roundtable* on ReachMD. On this episode, we'll hear from Dr. Michael Schweitzer, who's an Assistant Professor of Medicine and a pulmonologist and critical care medicine physician at University of Florida Health in Jacksonville. He'll be discussing misdiagnosis and underdiagnosis of COPD, as well as strategies for improving detection.

Here's Dr. Schweitzer now.

Dr. Schweitzer:

Several factors contribute to COPD being underdiagnosed and misdiagnosed, and the numbers are staggering: an overdiagnosis range between 30 and 60 percent, while underdiagnosis of COPD worldwide can be as much as 70 percent.

The first factor I would highlight contributing to this is that spirometry itself is underutilized by primary care in hospital settings, even though it's the diagnostic gold standard. Many patients are labeled with COPD based purely on symptoms or imaging without objective confirmation.

Second, some symptoms are often attributed to age, deconditioning, obesity, or cardiac disease, especially in older adults. Dyspnea and chronic cough can overlap with conditions like heart failure, asthma, or other interstitial lung diseases.

Another factor to highlight is that patients frequently normalize their symptoms. Many smokers will gradually adapt to their lifestyle and avoid dyspnea or avoid doctors at all, therefore presenting late in the disease course.

Finally, there's heterogeneity within COPD itself. There are many phenotypes in COPD, and we're continuing to recognize even more: among those, chronic bronchitis, emphysema-predominant disease, asthma/COPD overlap, and some genetic conditions like alpha-1 antitrypsin deficiency. This can make recognition less straightforward, even more so if clinicians are not looking actively for them.

The most practical step to identifying and treating COPD earlier is by using spirometry more systematically in patients at risk. Any patient with chronic respiratory symptoms and a history of smoking or significant environmental exposure should undergo spirometric testing.

Second, clinicians should actively screen for symptoms during routine visits, particularly in smokers or former smokers. Simple questions about exertional dyspnea, chronic cough, sputum production, or reduced activity tolerance can identify patients who may need further evaluation.

Another step in recognizing these patients is recognizing who is at higher risk, and those will include individuals with occupational exposures, biomass exposure, or a family history of early emphysema. This is why we also screen for alpha-1 antitrypsin deficiency, and it becomes relevant since guidelines recommend testing all patients with COPD at least once with it.

Finally, early diagnosis allows earlier intervention, smoking cessation, vaccinations, pulmonary rehabilitation, and appropriate inhaled therapy, all of which will slow functional decline, improve quality of life, and, in some cases, even improve mortality.

Announcer:

That was Dr. Michael Schweitzer talking about how we can ensure timely and accurate diagnosis of COPD. To access this and other episodes in our series, visit *Clinician's Roundtable* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!