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Proactive COPD Care: Applying Education, Monitoring Strategies, and Guidelines to Practice

Announcer:

You're listening to *Clinician's Roundtable* on ReachMD, and this episode is sponsored by AstraZeneca. Here's your host, Dr. Charles Turck.

Dr. Turck:

This is *Clinician's Roundtable* on ReachMD, and I'm Dr. Charles Turck. Here with me today to discuss how we can take a proactive approach to managing chronic obstructive pulmonary disease, or COPD for short, is Dr. Allen Blaivas, who's a pulmonary critical care and sleep medicine physician at VA New Jersey Healthcare system in East Orange, New Jersey. Dr. Blaivas, welcome to the program.

Dr. Blaivas:

Hi, Dr. Turck, thank you for having me.

Dr. Turck:

Well, starting with some background, Dr. Blaivas, would you tell us about the triggers that contribute to COPD exacerbations?

Dr. Blaivas:

Well, I'd like to first define what a COPD exacerbation is because it's not always so clear when a patient is having a COPD exacerbation and we'll talk a little more about that. But really, what a COPD exacerbation is, is when a patient senses a worsening of their dyspnea, with or without a cough, possible sputum production, or change in sputum color or tenacity over the course of, let's say, one or two weeks. So that's really what it is. And then, it could be triggered by a number of different factors, either alone or in combination. You could get bacterial or viral respiratory infections, environmental pollutants, dust or anything like that. Certainly, occupational exposures. And of course, there's other factors that we don't always recognize that could cause it. Weather could sometimes be a trigger for people, humidity, and sometimes cold. Interestingly, even a few years ago there was a study that showed about 3 percent of COPD patients who were hospitalized with respiratory symptoms actually had pulmonary emboli, even when it was not clinically suspected. So there's a whole host of things that could actually cause the COPD exacerbation. And we're not always able to identify what it is.

Dr. Turck:

And what are the risks to and impact on the patient that are associated with these exacerbations?

Dr. Blaivas:

We know for sure that exacerbations negatively impact health status. It increases the rates of hospitalizations and readmissions and also causes disease progression.

We used to be taught that there can be—it doesn't always happen—but there can be a stepwise progression with COPD. So one way to think of COPD is just a downward slope, like the slope of a triangle going straight down, almost like a ramp. Another way to think of COPD exacerbations, and of course, it could happen in different ways in different people, but in some patients, they're kind of going along on a plateau and then they get an exacerbation and then they drop off pretty quickly. And they don't really make it back to their previous baseline. So if you think of it as a stepwise progression, that's useful. That's really what could happen with exacerbations.

The other impacts that it causes, the direct impacts, are increased airway inflammation, increased mucus production, and more air trapping, which is associated with the emphysema and chronic bronchitis, which is what COPD is. As we know, many patients have other comorbidities, including heart failure or other acute illnesses. They could get pneumonia, or they could get a PE, as we mentioned already, that may mimic or aggravate COPD exacerbations. The cardinal symptom of COPD is dyspnea, but because they have so many comorbidities, we really also have to, besides thinking about what the impact that this exacerbation has, we also have to consider other comorbidities, as we mentioned, like PE or CHF or something along those lines. There are patients who are susceptible to frequent exacerbations, which we define as two or more exacerbations, and these patients, when they get these exacerbations, almost like we described what the stepwise decrement in their function, they have worse overall health status and morbidity compared to even patients with less frequent exacerbation. So it's exacerbation-specific.

And one of the most important things to point out is that about 20 percent of patients, when they recovered somewhat from their pre-exacerbation state, they still have ongoing symptoms, as we described in that stepwise progression. And for some reason, which is not well understood, it probably has to do with the hyper-inflammatory state, exacerbations tend to cluster. So they end up with one exacerbation begets a second exacerbation. So they tend to have these events pretty close together.

So those are all things that could happen when one gets an exacerbation and has to be thought about.

Dr. Turck:

For those just tuning in, you're listening to *Clinician's Roundtable* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Dr. Allen Blaivas about the risks associated with COPD exacerbations.

So given those risks, Dr. Blaivas, let's zero in on how we can implement proactive care into clinical practice. First, how do you educate your patients with COPD about exacerbations?

Dr. Blaivas:

Well, the most obvious thing we need to really get across to our patients, which I think most of them already know but have difficulty doing, is quit smoking. That's probably the single most thing and intervention that we could do to influence the natural history of COPD, improve their daily symptoms, and decrease the frequency of exacerbations. We also need to make them aware of other household and outdoor air pollution, poor weather conditions, and poor air quality. So these things can cause problems for these patients and definitely increase their risk of having an exacerbation. They also often have continued occupational exposures or even exposures in their home. So these are things to really be on top of and explain to the patients that they should be aware of.

The patients need to be up to date on vaccines, including influenza and pneumococcal vaccines, RSV, and COVID-19 vaccinations. All these things are important to prevent illness. And of course, we need to initiate appropriate bronchodilator therapy, including long-acting muscarinic antagonist and long-acting beta agonists, which have been shown to reduce the frequency of exacerbations. Inhaled corticosteroids may be helpful in this regard as well. When we do get them on bronchodilator therapy in order to make sure that they stay healthy and be proactive, make sure they know how to use their device and ensure that they are using the device correctly and with proper compliance. So these are all things that we like to check when a patient comes in to really ascertain when a patient is having symptoms or is prone to exacerbations, you want to make sure that they're using their device correctly and know how to use it, and watch them do it. I typically would have the patient test his device with me in front of me so I really get a sense of what they're doing and how they do it.

Dr. Turck:

And what monitoring strategies do you use to keep an eye on patients who might be at risk of an exacerbation?

Dr. Blaivas:

So we don't have any specific monitoring that we typically do. However, this might change in the very near future as there has really been an advent of remote patient monitoring devices. Some of these devices include spirometers, pulse oximeters, and electronic inhalers; they're called smart inhalers. We know patients have wearable sensors that they have on their smart watches and things like that, which many patients have nowadays.

And these have lifestyle data, and they show physical activity, heart rate, pulse ox data sometimes, and also sleep patterns. So the patient can do a lot of self-monitoring, either if they have the remote patient monitoring devices or even on their own with the wearable sensors. So these are all things that the patient should be aware of and can put to good use to see if these are helpful for them and really help them detect when there's a change in their pattern. As we know, physical activity is reduced in patients with COPD, which really leads to a downward spiral of inactivity. So if they see and they sense that they're becoming more and more short of breath and

they're becoming potentially more and more deconditioned, that will affect their quality of life. So they really need to be proactive in getting into somebody and see what they could do to make sure that they are being treated appropriately and they're getting what they need.

We also know, interestingly, that many small and mild exacerbations occur without a patient seeking out any specific care, and they improve on their own. But those can have long-term consequences, even those “small exacerbations” and I call them “small” sort of in quotes, but they're not small because they do have clinical significance, especially if they keep occurring.

So the COPD patients really need to be educated to understand the symptoms of their exacerbations and to act before there's a significant clinical worsening.

Dr. Turck:

You started to touch a little bit on treatment before, but there's something else I wanted to get into and that is, as I understand it, the 2024 Global Initiative for Chronic Obstructive Lung Disease, or GOLD Report, recommends initiating early triple-therapy in patients who have a high symptom burden and are at increased risk of exacerbations. I was wondering if you could tell us a little bit more about that and how it fits into proactively treating patients?

Dr. Blaivas:

Sure. Good question. The GOLD Guidelines recommend the use of inhaled corticosteroids in addition to the standard LABA and LAMA, the long-acting beta agonist and long-acting muscarinic antagonist, that we use in frequent exacerbators. Particularly those who have a lot of exacerbations, they should be potentially on triple-inhale therapy, which includes the inhaled corticosteroid in addition to the LABA and LAMA. And tripled-inhale therapy has been shown to improve lung function symptom and health status and reduce exacerbations when compared to LABA and LAMA alone. So in these patients and the patients who we'll talk about in a second that might be more susceptible to the inflammatory effects and might benefit more from a corticosteroid, these patients can be started on it, even immediately, as their first-line therapy. Most patients will probably get a LABA/LAMA at the offset. But an inhaled corticosteroid can be useful in some of the patients at the beginning.

And some of the patients that really have been shown to have benefit from inhaled corticosteroid are those that if they have asthma, concomitant to their COPD, or if they have higher eosinophils, usually we say over 300 for sure. If it's between 150 and 300, the data is not quite as strong, but also its suggestive that there is benefit. And adding an ICS, there's been some studies and recent data, mostly post-hoc analysis, have shown that triple therapy with ICS and LABA/LAMA compared to LABA/LAMA alone actually improves mortality in symptomatic COPD patients with a history of frequent and/or severe exacerbations. So it’s definitely useful, and it's definitely something that can help the patient both clinically and long-term potentially as we're seeing that there might even be mortality benefits.

Dr. Turck:

And before we close, Dr. Blaivas, taking a global perspective here, what kind of impact can a proactive approach to COPD care have on our patients?

Dr. Blaivas:

We've talked a lot about how important self-management interventions are for patients with COPD, so of course, we want them to be proactive. Self-management includes having frequent interactions between the patient and the healthcare provider. And this really supports behavioral change and motivating the patient, engaging patients to change their behavior and learn skills to successfully manage their disease. Primary interventions, which are easy to prescribe but not necessarily easy for the patients to do, include regular exercise, maintaining a healthy weight, getting vaccinated on time, avoid going out and avoiding adverse environmental situations, like cold or humid weather, or poor air quality days, stay inside, use an air conditioner, keep the window closed. Using breathing techniques, like pursed-lip breathing when a patient is short of breath. Too often we have our patients who tend to just reach for their inhaler. But the self-management and not really understanding the disease, they know that if they learn breathing techniques to slow their breathing, they often get the same benefit. Make sure they get adequate sleep; they take their meds as prescribed and are taking it appropriately using the devices correctly. These are all likely to be helpful and impactful, really to be proactive and change the way that they manage their disease and their approach to the disease. And also make them feel more empowered. So that's really what we're trying to drive home is that the patient really can control their disease.

Dr. Turck:

Well, given just what kind of impact a proactive approach can have on our patients with COPD, I want to thank my guest, Dr. Allen Blaivas, for joining me to share these essential strategies. Dr. Blaivas, it was great having you on the program.

Dr. Blaivas:

Thank you for having me.

Announcer:

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