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COPD Care: Partnership Between Primary Care and Pulmonary Providers

Announcer:

Welcome to *Deep Breaths: Updates from CHEST* on ReachMD. This CME activity, titled “COPD Care: Partnership Between Primary Care and Pulmonary Providers” is brought to you by The American College of Chest Physicians and is supported by Regeneron Pharmaceuticals Inc.

Before starting this activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives. And now, here's Dr. Megan Conroy.

Dr. Conroy:

This is CME on ReachMD, and I'm Dr. Megan Conroy, an Assistant Professor of Medicine and Associate Program Director of the Pulmonary and Critical Care Fellowship at The Ohio State University in Columbus, Ohio. Here with me today to discuss partnership between primary care and pulmonary for chronic obstructive pulmonary disease, or COPD for short, is Dr. Nathan Falk, who's the founding Program Director of the Florida State University Family Medicine Residency Program in partnership with Winter Haven Hospital. Dr. Falk, it's great to have the chance to speak with you today.

Dr. Falk:

Thanks, Dr. Conroy. It's great to be here and have a chance to speak with you as well as we talk about how we can form these partnerships between primary care and pulmonary medicine for the care of our patients with COPD.

Dr. Conroy:

Absolutely. To start us off, Dr. Falk, I'd like to hear your perspective as a family medicine physician. When patients are coming to you with COPD, what are some of the common signs and symptoms that you're seeing in the primary care setting?

Dr. Falk:

Yeah, that's a great question, Dr. Conroy. So when people come into primary care, they're coming in for a myriad of concerns and complaints throughout the course of their visits. And so some things that might clue us into a COPD diagnosis are often patients who are coming in with this chronic, usually more dry cough, rather than being significantly productive—sometimes it is more productive, but usually at the start, a drier kind of chronic cough. Often shortness of breath—particularly as it starts, more shortness of breath with exertion, maybe they're having more trouble getting up and down the stairs, walking out, mowing the lawn, or doing other things of that nature. Might even have some chest tightness. It's an obstructive process. So very rarely, they might come in with the more technical, “I feel like I'm wheezing.” That's not the most common symptom, but most the time it is those folks who are coming in again for that chronic cough, maybe a little bit of shortness of breath, and that kind of situation.

So now, Dr. Conroy, how does that compare to signs and symptoms that you typically see by the time they get to you as a pulmonologist and either they've already got the diagnosis of COPD, or they're coming up from a referral from a PCP for these symptoms maybe that aren't explained, and the PCP either hasn't worked them up or hasn't figured out exactly what's going on yet?

Dr. Conroy:

Yeah, absolutely. For the most part, in my practice, the patients coming with COPD after having been found by their primary care doctors have pretty good disease state education. It's always amazing that with the many things that a primary care physician needs to balance, they can really advance care and education for a patient.

And so the patients that are making it into the pulmonologist's office, they might be the mild COPD-ers that don't have a high symptom burden, and maybe are controlled by their first-line inhalers, but most often we're seeing patients not only with that cough, but also with trajectory of exacerbations. Flares are coming up a couple of times a year, they're getting that viral upper respiratory tract infection, or they're having different exposures to weather changes and such that are really bringing on some more exacerbations of their chronic obstructive pulmonary disease.

Certainly, in more advanced disease, I'll also see patients with significant dyspnea and exercise limitation—really limited even despite some of our first- and second-line interventions on things. This is something, being a chronic disease, that often comes on slowly, and so patients will make small adjustments to their life, to their habits, to the things that they're doing and how far they're walking and the heavy things that they're carrying or not. And it can often be revealing as you reflect with the patient on the ways in which they have slowly amended their life to compensate for their symptoms.

Additionally, looking at some of these patients, we'll often see hypoxemia more commonly in more end-stage COPD. And so we're finding a progression of the symptoms that you're seeing in early diagnosis that may be more difficult to control in more advanced disease.

Dr. Falk:

So as you start to see some of these folks come into the office with some of these signs and symptoms, and you maybe suspect COPD for a patient, what diagnostic tests do you start to order and consider as you're making this diagnosis?

Dr. Conroy:

Yeah, absolutely. As I've already stated, this is predominantly an obstructive lung disease, and the testing that we need to be able to diagnose that first and foremost is spirometry. And this could be in-office spirometry, but often, spirometry done in the pulmonary function lab might be of higher reliability. And finding that obstruction—we're finding an FEV1/FVC ratio that is below the lower limits of normal for their age by our ATS criteria, or less than a ratio of 70 by our GOLD report criteria. Sometimes it takes a little bit of clinical knowledge and circumstance to the patient's presenting symptoms and their risk factors to be able to determine between those criteria of our PFT standards for reading of below a lower limit of normal for obstruction versus less than 70. But for the most part, in an older population with a history of smoking, you can use that cutoff of a ratio less than 70 as indicative of obstruction.

The next full pulmonary function testing can be helpful in COPD. We may see an increased total lung capacity or an increased residual volume to suggest air trapping and hyperinflation as a consequence of that longstanding obstruction. We may also measure a DLCO, or diffusing capacity for carbon monoxide, and find that to be limited and reduced in COPD as a consequence of those emphysematous changes. Once we have those diagnostic tests, we'll trend spirometry over time to see if we're finding worsening in their obstruction and to help us consider the grading of that severity of obstruction.

I'll also be interested to look at a patient's fitness. So specifically, using things like a six-minute walk test, which can measure the distance a patient is able to walk in six minutes. Not complex, it but has meaning as we follow it over time to look at their exercise capacity, and it gives us information about their heart, their blood pressure, and their oxygen saturations. So it can be a way to pick up signs of exertional hypoxia, which we might see before resting hypoxia in COPD.

As for other diagnostic tests, aside from lung function testing, for any patient with new diagnosis of COPD, it's reasonable to think about screening them for alpha-1 antitrypsin deficiency by checking an alpha-1 level. There's even some oral swab tests that can be done in the office. But in general, all patients diagnosed with COPD should be screened for alpha-1 antitrypsin deficiency of heritable forms of COPD at least once.

And then the other component that really becomes important in some of these complex patients—as I noted, having uncontrolled dyspnea or exercise limitation, certainly, we want to look at lung function testing to make sure we're correctly diagnosing the obstructive lung disease—but what often also becomes necessary in these patients, particularly with high symptom burden, is to consider additional etiologies and comorbidities that can be impacting this. For patients with strong smoking histories, they independently have risk factors, therefore, for coronary artery disease, and they may have ischemic heart disease overlying that. There may be concurrent asthma of additional inflammatory obstructive lung diseases and overlap syndromes that we see there, and we need to treat two obstructive lung diseases at once, and not just one. So thinking about some of the ways that other disease entities can impact their symptoms may dictate additional diagnostic testing.

For those just tuning in, you're listening to CME on ReachMD. I'm Dr. Megan Conroy, and I'm speaking with Dr. Nathan Falk about diagnosing and managing COPD.

So now that we have some background on diagnosis, let's discuss the next steps. Dr. Falk, how are you evaluating patients in the primary care clinic after having some initial testing?

Dr. Falk:

Yeah, that's a great question. And to piggyback on something you just mentioned about other diseases, ideally, a lot of that work up around looking at coronary artery disease, someone's coming in with exertional shortness of breath, do they need an echo? Do they need cardiac evaluation? Just getting some basic labs, making sure that they don't have anemia. Certainly, in someone who has COPD, usually we expect their hemoglobin to be normal, if not a little bit high. And if you see someone with anemia who you might suspect has COPD, you've got to go chasing after that and what other underlying disease states are there.

And then once we have that initial evaluation and testing done, we want to make sure that, from a primary care standpoint, in addition to other disease states, we are taking holistic care of them, including making sure they're up to date on immunizations and their vaccines, like getting their annual flu shots and COVID vaccines, RSV vaccines, if appropriate, Tdap since we're seeing a pertussis outbreak in many parts of the country now—that's really our job on the primary care standpoint. And we're very appreciative for the pulmonologists who think about these things too. But that shouldn't be your job by the time they get to you guys.

So from your vantage point, Dr. Conroy, at what point during this whole process should primary care physicians refer to you guys in the pulmonary world? And what would you maybe prefer to have done on the front end as you guys are going? Do you want us to be ordering? Even sometimes we'll think about ordering imaging, whether that's a chest x-ray, which we know can have some nonspecific findings or chest CT. Certainly, we should be ordering their low-dose lung cancer screening and CTs as applicable. But what would you like to see? And at what point do you want that referral sent over to you guys?

Dr. Conroy:

Yeah, absolutely. I think the short answer is really at any time. I think it's individualized for that patient and their needs—if it's a patient who needs more disease-state education, who needs further intervention to be able to find the correct inhaler that they can take reliably and correctly for appropriate drug delivery; if that's a patient who sometimes just prefers to have a visit or two with a specialist to make sure that they're doing everything they can to optimize their treatment, always happy to see them.

And certainly, as you describe those patients who, despite starting their LAMA and their LABA inhalers combined with the presence of dyspnea or exacerbations with their COPD but are still having burdensome daily symptoms or are still burdened by frequent exacerbations, that's absolutely a patient appropriate for us to see.

I really will want to see that we've had spirometry done on record to confirm the diagnosis, and then any other workup that's been done, as you've already described, for comorbid conditions. On the whole, we're thinking about spirometry, a good symptom assessment, and then a lot of the preventive care that you've said. The importance of immunizations in this population really cannot be understated. And there's certainly several that they may qualify by the time they're 65, but they might qualify for earlier. I'm thinking about pneumonia vaccine boosters, RSV vaccine for those 60 and older with lung disease, which is different than the general population without lung disease. And so making sure that we're doing what we can to intervene from a preventive fashion is also very appropriate there.

Dr. Falk:

So one last question before we wrap it up for the day here, Dr. Conroy. Can you give us an overview of any advanced treatments that pulmonologists might pursue and things that are beyond the PCP scope, but would be important for us to know about for the co-management of our patients?

Dr. Conroy:

Yeah, absolutely. And I'll start with one therapy that I would not frame as being beyond a PCP by any means, but really noting the importance of pulmonary rehab and symptom control in disease state education. For patients who have COPD either with exacerbations or with burdensome dyspnea, the evidence for pulmonary rehab is pretty significant to improve that exertional dyspnea and improve their exercise fitness.

We'll also be looking then to evaluate for the necessity for oxygen therapy as optional on exertion, or if they're having hypoxia at rest with benefit to extend life. Then beyond that, depending upon how patients are doing, we'll think about adding additional inhaler therapies. So we've noted that the first line for treatment is a combination LAMA and LABA inhaler. But for patients with frequent exacerbations, and particularly those with evidence of eosinophilia that will suggest a presence of type 2 inflammation, that is when we'll add a third inhaled medication of an inhaled corticosteroid. Beyond that, for patients who are still exacerbating despite adequate inhaled

therapies who do have evidence of type 2 inflammation, we have some emerging role for biologic therapy of monoclonal antibodies that are targeting that type 2 inflammation that we know plays a significant role in COPD.

Beyond that, I'm also going to be looking at lung function testing for patients who are hyperinflated and with significant air trapping, but who have significant exercise limitation despite participation in pulmonary rehab—we'll think about the potential benefit for lung volume reduction. As we get that hyperinflation and over stretch those respiratory muscles, we can see significant improvement in dyspnea and quality of life and exercise capacity if we're able to reduce that hyperinflation. We've got options to do that through lung volume reduction surgery, which is done more invasively. Or evolving roles and increasing role for lung volume reduction bronchoscopically, where we place one-way valves that can decompress particularly hyperinflated areas of the lung. This is quite nuanced as to which patients might benefit from one or the other of these therapies, but there's certainly role for assessment for that, particularly in patients who are having that exercise limitation, despite pulmonary rehab and that hyperinflation. And then lastly, for patients with really significant disease and disease burden, we'll think about the possible benefits for lung transplantation therapy for COPD.

And that brings us to the end of our program. I want to thank Dr. Nathan Falk for joining me today to discuss diagnostic strategies and best practices for COPD. Dr. Falk, it was wonderful to speak with you today.

Dr. Falk:

Yeah, the privilege is all mine. It was great to get a chance to chat together and to educate our audience about how this partnership can exist between primary care physicians and pulmonology as we really try and take best care of our patients with COPD.

Announcer:

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