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Diagnosing COPD: From Symptoms to Assessment & the 2024 GOLD Standards

Announcer:
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Dr. Bhatt:
This is CME on ReachMD, and I'm Dr. Surya Bhatt. Here with me today is Dr. Meilan Han. Let's start with the patient case, Dr. Han. Can you walk us through this patient and tell us about your diagnostic assessment?

Dr. Han:
Sure. So this particular case is a 62-year-old gentleman, former smoker with roughly 40-pack-year smoking history. Also has a history of allergic rhinitis and controlled hypertension. Presents with a persistent productive cough, shortness of breath on exertion, and one exacerbation in the last year. FEV1 to FVC ratio is 0.54 with a post-bronchodilator FEV1 of 45% predicted, which suggests significant airflow obstruction. CAT score, or COPD Assessment Test score, is 20, suggesting significant symptoms. The blood eosinophil count for this gentleman is 275 cells/mcL. And this patient also has an IgE count of 107.

Dr. Bhatt:
Thank you. I think this sounds like a patient that we commonly see in our practices. How should we interpret these results? Which are the most important factors to look at?

Dr. Han:
Well, the first thing is that the patient does have, in my opinion, based on history and spirometry, confirmed airflow obstruction and likely has COPD. So I think that's the first thing. And then the second thing that we need to think about is treatment and where does this patient land. So they have significant symptoms, but are not quite in that high-risk group for exacerbations with just one event in the prior year. So that really puts this patient really, into a GOLD B category, when we think about the GOLD stratification of patients.

Dr. Bhatt:
Is there anything that might point you towards type 2 inflammation in this patient?

Dr. Han:
So that's a good question. The patient's eosinophil count is 275, which, at least at the University of Michigan Health System where I practice, would have been rounded up to 300. So they're definitely a little bit on the higher side. IgE is also a little bit on the higher side. They also have a history of allergic rhinitis. So certainly, if this patient were to potentially have a second event, this is something where I would potentially consider moving them up to an inhaled steroid. I think, at the current moment, they would fit into the GOLD B category, where we consider them for dual bronchodilator therapy, which would really help with symptom control. But literally one other event, and I would be pushing them up at least to an inhaled steroid.

Dr. Bhatt:

Thank you, Dr. Han. I think there's also increasing discussion now in the field about the importance of single exacerbation events and not necessarily needing to wait for two exacerbations to make major treatment decisions, now, given the impact of each exacerbation on a patient's disease course. I think you touched upon very well that we need to determine disease severity, the impact of the disease on the patient's health status, and perhaps use some questionnaires to quantify this, and also certainly quantify the risk of future events such as exacerbations, hospital admissions, and death in order to guide therapy. And it's also important, like you mentioned, to assess comorbidities and modifiable risk factors to see what is it that we can do to change and alter the course of the patient's disease. And it's also important to assess biomarkers such as eosinophils to help guide our treatment decisions.

Well, this has been a great micro-discussion. Unfortunately, our time is up, so thank you for listening.

Announcer:
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