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How to Choose the Right Treatment for COPD

Announcer:
You're listening to CME on ReachMD. This activity, titled, "How to Choose the Right Treatment for COPD," is brought to you by The France Foundation along with the COPD Foundation and is supported by an educational grant from GlaxoSmithKline.

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Here's your host, Dr. Jennifer Caudle.

Dr. Caudle:
With the variety of inhaled therapeutic options for treating COPD, including single, double and triple combination products, clinicians are challenged to not only know which one to choose, but also, how to use the most effective therapy. And to help us navigate these difficult treatment options and decisions in COPD care, we have a panel of experts here with us today to shed light on how we can personalize our management approach to meet the needs of individual patient care.

This is CME on ReachMD. I'm your host, Dr. Jennifer Caudle, and today I'm joined by Dr. Byron Thomashow, Dr. Barbara Yawn and Miss Debbie Daro. Dr. Thomashow is a pulmonologist at Columbia University Medical Center, and he serves as a Chief Medical Officer of the COPD Foundation. Dr. Yawn is the Chief Science Officer of the COPD Foundation and a primary care physician at the University of Minnesota. And lastly, Miss Daro is a patient with COPD and is a COPD Foundation's New Jersey State Captain.

Thank you all so much for being here with me today.

Dr. Yawn:
Thank you for having us.

Miss Daro:
Thank you.

Dr. Thomashow:
Thank you.

Dr. Caudle:
Absolutely. So, let's start with you, Miss Daro, because I'd love to learn more about your story and your experiences. You know, when were you first diagnosed with COPD, and how do you currently manage it?

Miss Daro:
I was first diagnosed in, um, early 2013 by a primary care doctor based on an x-ray showing hyperinflated lungs, but a couple years I didn't do very well, and then I saw a pulmonologist, and she very quickly got me into pulmonary rehab. That's also when I had my first spirometry test, actually a full pulmonary function test, and at that time I was already stage 4. My lung function, uh, fluctuates between about 28 to 24%, so I had very severe obstruction, but I have some moderate diffusion, so my $O_2$ saturation isn't too terrible, which is

fortunate for me, and I also don't have chronic bronchitis, simply emphysema. As I said, the pulmonologist had seen my numbers, um, right away got me into pulmonary rehab, so I started exercising, and I started to feel a little better. It's—it's a very slow process. You don't feel better right away. It takes a lot of effort and it takes a lot of time, but I did start to feel better. I still exercise to this day, , despite being GOLD stage 4, I still work full-time. I'm a programmer. I live independently in my own house, and I, you know, I manage. It's still a bit more difficult. I get breathless and I'm a little bit slower, but I do manage, I do get by, so I'm living a very good quality of life despite the severity of my disease.

Dr. Caudle:
Excellent, and—and thank you so much for sharing that, Debbie. You know, turning to you now, Dr. Thomashow, can you outline the typical management approach to COPD?

Dr. Thomashow:
Yeah, sure. I mean, I—I think it's important to stress from the beginning that COPD, despite its impact, is a preventable and treatable disease. We have a number of therapies. We have medication therapies that we're going to talk about a bit. We have exercise programs like pulmonary rehabilitation. There's a lot that we have to offer. Part of the problem is that so many of these people go undiagnosed. There's an under-appreciation of symptoms. It's very important that we diagnose this earlier so that we can begin our treatments earlier and make more of a difference.

Barbara, I know you have had that sort of experience as well in primary care.

Dr. Yawn:
Certainly have. And it's really important to hear that with appropriate management, people like Debbie, even with, you know, very severe disease, can get out and can function. She's still working full-time. Debbie, I—that's just amazing to me, and it's wonderful,

Dr. Thomashow:
I agree with that completely. Around 12 years ago, the COPD Foundation launched its, uh, COPD Pocket Consultant Guide. Over the years the foundation has distributed over 800,000 of those hard copies to providers around the country, and over the last year or 2, we've developed an app, which is free either in the App Store or Google Play, that provides, we think, some very simple and important information for providers and patients. we now understand that, uh, that 25% of people in this country with, uh, COPD never smoked at all, and increasingly around the world other exposures to biomass fuels and pollution are becoming much more major factors. Is it important to stop smoking? Certainly. Is it important to never start smoking? Certainly. But COPD is far beyond cigarette smoking. There are lots of issues that we need to deal with.

So, beyond smoking cessation, which is important, there's also an issue that I know Barbara feels strongly about, is immunization. I mean, despite our efforts, flu and pneumonia vaccines are underutilized, and those are very important in keeping everyone healthy, particularly people with COPD.

There's pulmonary rehabilitation, there's oxygen therapy, and I think it's important to recognize that, like many other chronic diseases, COPD patients have many comorbid conditions and that you can't really treat this disease without treating the person who has the COPD.

Dr. Caudle:
And when it comes to medical therapy, let me come back to you, Dr. Thomashow. How do you take a personalized approach to the therapies?

Dr. Thomashow:
Well, you know, I think that's really important. It's important to evaluate or assess the severity domains, the, uh, the presence of degree of obstruction on spirometry, the degree of the symptoms. Uh, exacerbations are very important. because they can lead to more rapid deterioration, and yet, uh, we have many things we can help to prevent them and treat them. The importance of using oxygen, if necessary, the degree of emphysema, the presence of chronic bronchitis, the presence of comorbid disease, these are severity domains, treatable traits that you might call that are really important to evaluate. there's a simple questionnaire called the CAT, which is the COPD Assessment Test, which is on our algorithm for the COPD Foundation guide which allows you to define where a patient is, allows you to determine, uh, how limited they are.

Uh, Barbara, I know that has not had much impact in primary care. I wish it did. Your thoughts?

Dr. Yawn:
Well, I agree. Uh, you know, I have trouble remembering all of the questions I should ask for all of the many chronic diseases, uh, that affect the people that I see, and the CAT is one way to get all of those questions asked, and it can be done, uh, before you see the

patient they can fill it out while they're waiting to see you. And I like using the questions within the CAT. There are questions about cough and phlegm, and that helps me think about chronic bronchitis. There are questions about fatigue. There questions about sleeping So I think the CAT has many potential uses for those of us in primary care trying to deal with multiple morbidities.

Dr. Thomashow:
Yeah, I agree with that, Barbara. And, you know, going back to that personalized approach, uh, you can use the CAT, you can use some of the other—the parts of the algorithm to determine what your therapies would be. So, for example, in those patients with mild disease, it's probably reasonable to start with a single agent, a LAMA or a long-acting muscarinic agent. Generally, these are once a day or occasionally twice a day, but, uh, most of them out there are once-a-day medications, and they are often fairly, uh, fairly effective, very effective indeed. Uh, in those people with more significant disease, uh, more recently we've moved to combination therapies, uh, a long-acting muscarinic and a long-acting beta agonist, a LAMA plus a LABA, uh, and there are now these once-a-day medications which are available. Uh, there's a lot of evidence suggesting that combining these 2 drugs is more effective than any single agent alone without any evidence of increasing side effects, so, uh, they are very helpful. And indeed there's evidence suggesting that these agents not only can decrease symptoms but can help prevent exacerbations.

In those patients with more severe disease with exacerbations, those patients who continue to struggle despite combination therapy, you might very well move to a triple therapy with the addition of inhaled corticosteroids. Uh, all of these things can be helpful, uh, but the 2 things I want to really stress is that whatever route of medications that—that we use, that it's important to understand that you need to use the inhalers correctly. And I know, Barbara, that that's something that you feel very strongly about.

Dr. Yawn:
I certainly do, because when we're prescribing a therapy, we're not just prescribing a medication; we're prescribing a delivery system You have to know how to use those, because if you don't use them properly, you're not going to get the medication where you think, and it's an adherence issue. If—if the patients are trying to take it but it's not getting there, uh, it's really a problem, so we need to know the differences in different kinds of things like the metered dose inhaler, the dry powder inhaler, uh, the new soft mist inhalers, even nebulizers. We need to know how to use those, and we need to know how to teach our patients. Uh, that's one thing that's on the app that we talked about. For example, uh, in your office you can pull the app up and actually watch the app, with the patient to teach them how to do it. And then, of course, you want to watch people.

Debbie, have people taught you how to use each of our different inhalers, and do they watch you use them when you go in for appointments?

Miss Daro:
Um, when I was first prescribed inhalers, I was simply told that she was going to prescribe some puffers for me, and that was it. That was the extent of my inhaler education. Um, so I came home and I went online and I found some videos, um, so I knew how to use my puffer, "puffer." Of course, now I—I use, um, 3 different kinds of medications and also a short-acting beta agonist, um, and I have had some demonstrations on how to do it. I think the videos of the 3 that the COPD Foundation has available are wonderful. Those are really great videos, and they also cover the different types of inhalers, because they are all different. I have 4 different inhalers, and they all work a little bit differently, um, but so the videos from the COPD Foundation are great. They also talk about using spacers, which is something a doctor never mentioned to me. I—I first learned about a spacer from a respiratory therapist, so that's... Yeah, that's a very good point. We are just—tend to be given medications and shown the door, and if we don't know how to use them properly —if you don't use them properly, you're not getting full medication.

Dr. Thomashow:
That is absolutely correct, Debbie. If you don't use the medicines right, they can't work,

Dr. Yawn:
And we as primary care cannot assume somebody else is going to do that education. We should figure out how to get that education done and then watching to make sure that education has been adequate.

Dr. Caudle:
Excellent. You know, for those of you who are just tuning in, this is CME on ReachMD. I'm your host, Dr. Jennifer Caudle, and here with me today are Dr. Byron Thomashow, Dr. Barbara Yawn and Miss Debbie Daro, a patient with COPD, who are talking about the available therapy options and other best practices for COPD.

Now, earlier, Dr. Thomashow, you spoke about some of the therapies available for COPD, but are there additional considerations when it comes to medical therapy for our patients? why don't we start with Dr. Yawn? Would you like to start?

Dr. Yawn:

Sure. Uh, Byron mentioned before that people who are on dual bronchodilator therapy and are still having exacerbations, we may need to go on and add inhaled corticosteroids. It's important to realize that the only role for inhaled corticosteroids at this point in time in people with COPD is with exacerbation prevention.

Uh, and I know, uh, Byron, one of the things that's coming out now is blood eosinophils and how they can help predict the, uh, use and need for inhaled corticosteroids.

Dr. Thomashow:
Uh, maybe. Uh, you know, I think that that has—that's not completely defined yet, Barbara. I think that the one thing I can say is, if eosinophil count in the blood is very low—let's say less than 100—that the role of—that there's probably much less of a role of inhaled steroid, and that the higher the eosinophil count, uh, as you get a 300 and higher, the more likely that there's a role for inhaled corticosteroids. And in between there's judgment that you need to use, but it is an area that is undergoing a tremendous amount of research now, uh, and it certainly presumably can help you to determine, uh, whether or not patients need to be on inhaled steroids or not. You know, I think that's something that we'll define further as we move along. Uh, I think that, uh, one of the things I want to stress is that inhaled corticosteroids are the mainstay of therapy for asthma, but while there is an overlap between COPD and asthma, they're not quite the same disease, uh, and the role of inhaled corticosteroids in COPD is far less clear. As Barbara said, it's mostly in those people with exacerbations.

I think it's important to stress that, uh, we have things that we need to prevent, we need to recognize, we need to treat exacerbations, uh, because that can make a tremendous amount of difference. Uh, and I really want to continue to stress that this is not just about a medication; it's not just about smoking cessation; it's not just about immunizations. It's also about exercise programs and pulmonary rehabilitation.

Dr. Caudle:
Those are really excellent points. You know, lastly, I'd like to hear from you, Miss Daro, about your treatment plan and in particular how exercise fits into that plan.

Miss Daro:
Well, as I had mentioned earlier, I was very fortunate to have a pulmonologist who right away seen my results of my pulmonary function test, understood that I needed to get into pulmonary rehab. I just want to mention that at my worst I had gotten very thin. I had, um, lost a lot of muscle mass. I weighed just a little over 100 pounds, which was very unusual for me, and I had difficulty just walking around the house, so—so that is what triggered my starting point. Um, this morning I got up at 5:30, I was out the door to the gym, and by, um, by 7:00 I'm on the stationary bike, and I did 30 minutes on the stationary bike; I was walking around the gym carrying 50 pounds of weights back and forth across the gym. So, exercise can have a very profound effect on your quality of life. My numbers haven't changed a lot, um, but over the years, because I've maintained a lot of exercise—I'm constantly challenging myself—I've built up all that lost muscle mass, I have increased my stamina and endurance, and I think the—the other thing that I've been able to do is better understand my breathing. I get very short of breath. We talked about air trapping. That's one of my big problems. I get very short of breath when I try to exercise, but I've had no choice but to come to terms with that and figure out how can I manage my breathing, how can I tolerate it, and basically not be afraid of it. I think a lot of people are terrified when they get short of breath, and that's understandable. I've kind of gotten to the point where I understand that I'm going to be okay, that I'm uncomfortable, and it's scary, but I'm going to be fine, so I'm able to just kind of work through it and keep going and keep exercising. And I'm absolutely convinced without a doubt that it's exercise that has me working full-time, living independently, taking care of the house and having the kind of life that I have.

Dr. Thomashow:
Uh, Debbie, you're a star. I agree with everything you just said.

**I'll just** make another point. We think pulmonary rehab as just being, um, walking on a treadmill, doing a stationary bike, whatever it might be. My pulmonologist also had me do a different program where I worked one-on-one with a, uh, trainer and respiratory therapist, and I did all strength training, and that was what really pushed me kind of over the top with all of this and enabled me to take my exercise to the next level, and I think that's what enables me to maintain what I do.

Dr. Yawn:
I think that's so important, Debbie. You know, you cannot overemphasize the importance of activity and increasing your activity. I also wanted to remind people that pulmonary rehab is really helpful for other things too. Most of the programs include a lot of education about what is COPD? what are breathing techniques? what is your medication? how do you take your medication? nutrition, for example. All of these things are included in pulmonary rehab, all the things we wish we had time to help our patients understand. And then you've got to keep doing things, as Debbie said, and again, the COPD Foundation app can help with that with their exercise videos.

Dr. Caudle:
Those are really wonderful points, all of you. And with that I'd really like to thank my guests, Dr. Byron Thomashow, Dr. Barbara Yawn and Miss Debbie Daro for speaking with me and our ReachMD audience about the management of COPD. It was really wonderful speaking with you all today. Thank you so much.

Dr. Yawn:
Thank you.

Dr. Thomashow:
Thank you for inviting us.

Miss Daro:
Thank you, and keep exercising.

Announcer:
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