Transcript Details
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Evaluating the Role of Steroids in COPD: What We Need to Know

Announcer Introduction:
You're listening *to Deep Breaths: Updates from CHEST* on ReachMD. This is a non-promotional, non-CME disease state disease education podcast series brought to you by American College of CHEST Physicians in collaboration with and paid for by GSK.

Dr. Turck:
Welcome to *Deep Breaths: Updates from CHEST* on ReachMD. I'm Dr. Charles Turck and joining me to discuss the role of oral corticosteroids in COPD is Dr. Deborah Jo Levine, a Professor of Medicine and Director of the Pulmonary Hypertension Center at the University of Texas Health. Dr. Levine, welcome to the program.

Dr. Levine:
Thank you, Dr. Turck, and thank you to CHEST and ReachMD for allowing me to be on with you today to talk about COPD.

Dr. Turck:
So, let's just dive right in, here. Dr. Levine, based on your experience, what are the big challenges pulmonologists face when using systemic steroids for COPD?

Dr. Levine:
Well, I think some of the most significant challenges that both primary care, including hospitalists and outpatient primary care, as well as pulmonologists in and out of the hospital, focus in on is how and when and who should we be using systemic steroids for in COPD. And I think today we'll be focusing on many of these scenarios and why during this podcast.

Dr. Turck:
So, with that said, can you explain the role systemic steroids have in treatment like you were saying when and how they should be used in patients who are hospitalized with acute exacerbations?

Dr. Levine:
Well, that's a really great scenario to start with because the newest iteration of the Global Initiative for Chronic Obstructive Lung Disease, or the GOLD guidelines, point out that systemic steroids used for exacerbations in COPD can improve recovery, FEV1, and oxygenation. They've also been shown to reduce relapse, treatment failure, and length of hospitalization. These guidelines also recommend that oral corticosteroids are used based on the severity of the disease and the therapy duration should not be more than five to seven days. Usually, a dose of 40 mg of prednisone for five days is recommended but sometimes people ask 'should we be doing longer?' However, we understand that longer courses are associated with increased risks. So really have to weigh that risk/benefit ratio knowing that really the GOLD guidelines tell us five days is appropriate.

Dr. Turck:
And if we continue to focus on patients with acute exacerbations, how do their comorbidities affect our treatment approach?

Dr. Levine:
Well, it's important to evaluate patients carefully. When patients present with a possible COPD exacerbation, we need to remember, all shortness of breath or all symptoms related to this are not always COPD-exacerbations. We have to look at the differential diagnosis and also look at the side effects of steroids and how it may affect patients' other comorbidities of disease. It's important to remember that all episodes of increased shortness of breath, again, may be related to something beyond their COPD. So, it may not be a COPD exacerbation.

Patients may have other comorbidities that may worsen respiratory symptoms that are common in patients with COPD, and it's important to remember to consider every diagnosis they have or could have before treating a COPD exacerbation.

It's important to also understand that not all COPD exacerbations are treated the same. For example, a patient comes in and they have a mild exacerbation. They should be treated really with short acting bronchodilators, only. With patients who have moderate COPD exacerbations, they may be treated with short-acting bronchodilators plus antibiotics or oral corticosteroids. If a patient comes in and they have a severe COPD exacerbation, this patient may require hospitalization or a visit to the ER department for a full evaluation and adjudication on what types of medications and therapies this patient needs.

Another really important area is patient-clinician communication. It's so important when it comes to understanding the disease and understanding therapy. And the discussion should be had with patients early on because number one, not all exacerbations are reported to healthcare providers. Patients may just not think it's important if they have a short bout of short exacerbation. They may not even tell us. These exacerbations may be shorter, but they have a significant effect on status. So, it's important to educate patients about the importance of understanding what an exacerbation is, what the symptoms are, who to call, when to call, and when to seek emergency healthcare. Patients should also know their own triggers; this could be a viral infection, bacterial infection, reflux, pollution, change in temperature, all of these things can trigger an exacerbation and they need to be aware of that.

Dr. Turck:
Switching gears, a bit, let's take a look at patients with stable COPD. What does the GOLD report say about the role of oral versus inhaled corticosteroids in their treatment?

Dr. Levine:
In oral corticosteroids in patients with stable COPD, GOLD guidelines show us that really, although these steroids play a role in acute management of exacerbations, as we just discussed, they really have no clear role in the chronic daily treatment of COPD that's stable because of number one, lack of benefit against a high rate of systemic complications that they can provide. The use of oral corticosteroids in patients with stable COPD may lead to a suboptimal treatment regimen and educating patients and their healthcare providers is imperative. So, not just the patients but the patient's primary doctor or someone who is taking care of them in the hospital, maybe a hospitalist.

Dr. Turck:
For those just tuning in, you're listening to *Deep Breaths: Updates from CHEST* on ReachMD. I'm your host, Dr. Charles Turck and with me today is Dr. Deborah Jo Levine, and we are discussing the use of oral corticosteroids in the treatment of COPD.

Now, Dr. Levine, you've given us some really great insights into the treatment of COPD, so why don't we take those insights and apply them to a real-world patient case. Can you share a memorable patient case with us that demonstrates these treatment considerations?

Dr. Levine:
Yes, we recently had a 62-year-old man who with a history of COPD who was referred to pulmonary clinic after a hospital discharge for severe COPD exacerbation. He had actually been discharged sixty days prior to the clinic visit and this has not been an uncommon occurrent of getting late appointments, especially in the last couple of years. His inpatient treatment regimen was antibiotics, he had had an inhaled albuterol and ipratropium, oxygen, and he had an increased dose of OCS and his, the medications he was discharged on also included two maintenance inhalers, oxygen, and OCS. He hadn't even opened his two new maintenance inhalers.

He'd had three exacerbations in the prior year, and during that time, in and out of the hospital, he had been trying to taper his dose of OCS between these exacerbations, but he never really got off of them for two years. He thought, in his mind, he was unable to titrate down because at 20 mg of prednisone, he really felt good. He actually felt best between 25 and 30. And he actually thought, 'Well, I don't even need my maintenance inhalers when I'm on OCS.'

Dr. Turck:
And with that patient case in mind, I'd like to talk about some of the common challenges patients like him face while they're titrating down off oral corticosteroids. Can you tell us what those challenges are and how we can help our patients?

Dr. Levine:
Absolutely. And this is a common complaint that occurs with our patients while they're trying to titrate off or withdrawal their steroids. Patients feel body aches, pains, fatigue, joint pains, even lightheadedness, decreased appetite, they feel some GI symptoms like nausea and vomiting, they lose weight unintentionally. They also have more than fatigue, a feeling of weakness and because of this, we want to help them and they, they do not want to actually just go off the steroids because they feel like without titrating them, they feel good.

Actually, oral corticosteroids can have many, many adverse effects, though. This is what we need to educate our patients on. I know they're having symptoms or you have to relay that you know they're having symptoms related to the titration off the steroids, but we have to remind them that these are not benign medications. Depression, sleep disturbance, diabetes, hypertension, GI side effects, osteoporosis; all of these are actual adverse health effects that occur with steroids.

Dr. Turck:
And to wrap up, what should clinicians discuss with patients regarding oral versus inhaled corticosteroid treatments to ensure they understand our education on their medicines and COPD?

Dr. Levine:
So, I think when you're talking about all the management of COPD, we talk about global management of COPD, and I think that's a good place to start with patients. There's maybe steps of where they are. So, first of all when, remember to include that there's both pharmacologic and non-pharmacological therapies. But also, remember that there's plans for the patients that's optimal for them based on where they are in their disease. Oral corticosteroids may be needed in certain situations, whereas inhaled therapies are important in others. So, weighing the treatment efficacy, as well as the harm and applying that knowledge to the patient. And not only just the individual patient, but to where that patient stands in his disease. So, not even inter-patient, but intra-patient. Optimizing the maintenance regimen is really important and making sure the patient knows what the maintenance regimen is for, how to do it, and why it's important is also very beneficial. So, they know why they're doing things and they know what will happen or if they don't or do do it.

And again, being educated and involved in every part of the day-to-day process is important for patients. And so having them be the kind of, captain of the ship with us helping in every step is important for them to know.

Dr. Turck:
Well, with those considerations in mind, I wanna thank my guest, Dr. Deborah Jo Levine for walking us through COPD management strategies and the role of systemic steroids for our patients with COPD. Dr. Levine, it was great speaking with you, today.

Dr. Levine:
Thank you so much and thank you to CHEST and ReachMD and thank you for the opportunity and have a great day.

Announcer Close
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