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Evaluating Therapy Escalation for Patients with COPD

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 take a look at therapy escalation in patients with COPD is Dr. Hassan Bencheqroun, Assistant Professor of Medicine at the University of California Riverside School of Medicine. Dr. Bencheqroun, welcome to the program.

Dr. Bencheqroun:
Thank you so much.

Dr. Turck:
Let's begin with a little bit of background. Talk to me about what goals we should keep in mind in managing COPD in patients.

Dr. Bencheqroun:
Thank you for that question. COPD, for those of us that treat it in the clinic or even in the hospital, is not just a lung disease, it affects multiple systems. So, our goal in treating COPD is a two-pronged approach. One, manifests in reducing the symptoms that means reducing exercise intolerance, reducing comorbidities, and improving health status and quality of life, and reducing the risk, as well, which manifests in the disease progression, exacerbations, and if we can, reduce mortality, that would be ideal.

Dr. Turck:
Let's focus on the reducing risk portion. Can you explain why preventing exacerbations is so important for patients with COPD?

Dr. Bencheqroun:
Definitely. COPD is not a one-size-fits-all diagnosis. It's rather an umbrella that encompasses multiple, the word used these days is phenotypes, it's trying now to make its entrance into the literature. An exacerbator, for example, is one such phenotype. That means it's a patient who would have more than two exacerbations in the past year. So, when somebody has two or more exacerbations in the past year, that would be a patient that I would focus on because they tend to be more at risk of higher exacerbation percentage.

Dr. Turck:
How can you identify those patients who may be at a higher risk for COPD exacerbations?

Dr. Bencheqroun:
A lot of patients that are treated by physicians, whether in the primary care or in the pulmonary realm they bring several risk factors that the physician must be alert to. The first one would be as mentioned before, two or more exacerbations in the past year. Others would be the severity of airflow limitations, such as FEV1 reduction or FVC, perhaps the presence of gastroesophageal reflux disease, as it tends to increase the exacerbation risk, if there has been a sputum culture that has been done in the past that showed a bacterial colonization, those two tend to have more exacerbations, systemic comorbidities, as we mentioned COPD is a systemic condition rather than just a lung illness, older age, and lastly, the BODE index, which is an acronym that stands for 'B' as body mass index, 'O' for airflow obstruction, 'D' for dyspnea, and 'E' for exercise. The higher the BODE index, the more risk for exacerbations.

Dr. Turck:
Now, considering the GOLD 2021 recommendations, how and when is it appropriate to escalate therapy in patients with COPD?

Dr. Bencheqroun:
Usually when patients present to my clinic, I assess what inhalers and what medications they have been treated with in the past, as well as their history of exacerbation. Let's say for example, a COPD patient was just recently given that diagnosis, initiating treatment if they are naïve to any inhalers, we would start them with a single agent, long-acting beta2 agonist, or long-acting antimuscarinic. If that did not reduce the symptoms, whether exercise intolerance, or cough, or dyspnea, the patients themselves bring us what is most priority in their life and what do they define as quality of life. Then it is safe to go to the next step of combining the long-acting beta2 agonist and the long-acting antimuscarinic. LABA or LAMA, by combining them, it might actually improve their symptoms by saturating the receptors that they have in their lungs and in their airways. If this person continues to experience either exacerbations or symptoms or both, it is safe to escalate by adding an inhaled corticosteroid, the acronym being ICS, bearing in mind that ICS tend to have their own side effects, and patients may have preferences of not wanting to be on steroids. Side effects can be, for example, that the patient should rinse and gargle their mouth to make sure that there's no developments of any hoarseness of the voice or accumulation of the inhaler in the back of their throat. Initially we also seen that there is an increased risk of pneumonias on ICS that has been validated in the literature. However, they have shown their benefits. So, a patient-centric approach by which approach to have, adding ICS or not, is relevant in this juncture.

The escalation can tend to be sometimes a preference by each physician, some reach out directly to a triple therapy that is maintained in one inhaler. So, the one inhaler triple therapy has shown an incredible improvement in patient compliance, patient acceptance of that inhaler, and patient delivery of medication to their lungs.

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 I'm speaking with Dr. Hassan Bencheqroun about therapy escalation in patients with COPD.

So, Dr. Bencheqroun, let's apply those GOLD recommendations and considerations. What are some signals that make you consider treatment escalation in your patients?

Dr. Bencheqroun:
Thank you Dr. Turck. Patients that come in to see us with the diagnosis of COPD, as we mentioned, we need to prevent exacerbations and reduce the symptom burden. As such, one of the things that I do is I start asking the patient on the first time that I meet them, what are the elements in their life that are priority to them that COPD has limited them to do and then those are my markers to see whether we can improve the patient's quality of life and exercise intolerance to reach those goals. Some just want to play with their grandchildren in the yard, others want to be able to blow their birthday candles. They are much more achievable goals than we tend to think.

In addition, it helps to have a dyspnea questionnaire that is validated for COPD and there's many of them that are online or in the literature that one can look for and they can fill them out while they're waiting in the waiting room and that helps to have a measurable improvement or worsening of that symptom.

And lastly, asking about exacerbations. Unfortunately, the last one seems to be the toughest one because when patients have exacerbations, they may not be aware of them. So, as I mentioned before, I tend to ask them a generic question, stating, 'In the last year, how often every month or every week, do you have symptoms that lead you to calling your doctor or even seeking medical attention at an urgent care or the emergency room?', and many patients would tell me, 'Oh, on a weekly basis, I have these episodes,' and I record that name 'episodes' and that's how I start asking them moving forward about exacerbations because they don't recognize the words.

Dr. Turck:
What are some barriers to timely therapy escalation in the setting of recurrent exacerbations?

Dr. Bencheqroun:
It's a very important question. I try to classify those barriers, both physician-related or patient-related. From the patient-related perspective, patient follow-up with the doctor tends to be somewhat erratic and no patient wants to call to their doctor. They called because they have to. And sometimes they can push that until they really need to, and it makes it incumbent upon us sometimes to make these phone calls, just a well check from my office in order to make sure a COPD patient with a exacerbator phenotype in my practice is checked on regularly and we generate these questions and comments from the patient, including sometimes not refilling their inhalers, or not reporting to us an increase in cough production.

From the physician perspective, we tend to be sometimes busier some days than others and if it happens to be a day where an exacerbator phenotype is schedule to be seen, we may not be asking them the questions about symptoms or about whether they went back to smoking again. It has been a pandemic, many patients fell back into the smoking habits, etc. So, those barriers need to be very

present in our minds.

Dr. Turck:
And when it comes to personalizing treatment with therapy escalation, how should clinicians go about selecting an appropriate inhaler for their patient?

Dr. Bencheqroun:
This is a very important question. I thank you for asking it. So, personalized treatment means that we need to ask our questions and to get to know them a little bit. The cost of inhaler is one of the most widely known barrier and that cost can change. Sometimes patients in the open enrollment may have changed insurances and that cost have changed and they may drop a certain therapy without telling their doctor. Also, when choosing an inhaler, one has to make sure that when the patients comes back to bring it with them and demonstrate that they are able to use it; they may have arthritis in their hand, they may have advanced dementia and they would not have the coordination between their mind and their hands. Other patients tell me that they prefer a mist versus a dry powder. So, intimately knowing those inhalers can help the physician prescribe the one that is most likely to meet he adherence of the patient.

And lastly, after every exacerbation, sometimes the patient is short of breath and they may not benefit from an inhaler as much as a nebulizer, which we can utilize for a short amount of time until they have recovered their flows and their strength to get the dose they need from the inhalers.

Dr. Turck:
Before we close, Dr. Bencheqroun, do you have any final take-aways you'd like to share with our listeners?

Dr. Bencheqroun:
Some of the lessons learned when it comes to COPD is number one, patients tend to not want to have too many inhalers in front of them. So, if we can, consolidate them into a single inhaler, it would be much better for the patient, it would increase the adherence, it would actually increase the delivery of the medicine one wants to give to their patients. Also, reducing symptoms and preventing exacerbation is one of the top priorities that we need to have in terms of our continuous maintenance of therapy for our patients. And we need to generate these questions from the patient because they're not going to passively bring them to us. Recognizing someone as a candidate for therapy escalation either because their symptoms are worsening or they have new symptoms or they have more exacerbations. Personalizing the treatment, meaning the inhaler selection, as well as the patient factor. And lastly, continuing to have a dynamic relationship with our patients with regards to their pharmacology therapy or their future exacerbations and escalate when appropriate. These are all lessons learned along the way that I wish to share with my colleagues in order to start to make headways in the war that we have with COPD exacerbations, in general.

Dr. Turck:
Well, with those final thoughts in mind, I want to thank my guest, Dr. Hassan Bencheqroun for discussing therapy escalation in patients with COPD. Dr. Bencheqroun, it was great speaking with you, today.

Dr. Bencheqroun:
Dr. Turck, thank you so much for helping me navigate this episode and I want to thank ReachMD, GSK, as well as CHEST for affording me the opportunity to share these lessons learns with my colleague. Thank you.

Closing Announcer:
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