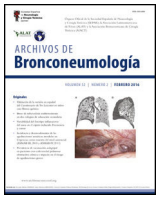
Archivos de Bronconeumología 58 (2022) T1–T2

Sociedad Española de Neumología y Cirugía Torácica SEPAR

ARCHIVOS DE Bronconeumología

www.archbronconeumol.org



Editorial

[Translated article] GesEPOC 2021 and GOLD 2021. Closer together or further apart?☆

GesEPOC 2021 y GOLD 2021. ¿Más cerca o más lejos?

The recent publication of the new 2021 update of the Spanish COPD Guidelines (GesEPOC 2021)[1] prompts the perennial question: do we really need national guidelines if a global document like the Global Initiative for Objective Lung Disease (GOLD) is available?[2] The answer is very simple and can be found in the GOLD document itself: GOLD is a global strategy that must be adapted to the needs and characteristics of each country or region. This is what GesEPOC aspires to, and most of its recommendations coincide with or are clearly derived from those of GOLD.

The definition of the disease and most of the treatment recommendations in both documents are practically identical, since they are drawn from the evaluation of the same evidence. GesEPOC even proposes the same blood eosinophil cut-off points for recommending the use of inhaled corticosteroids (ICS). Two notable differences are perhaps the following: firstly, GOLD continues to make no specific recommendation for use of mucolytics/antioxidants in COPD[2]. This contrasts not only with GesEPOC[1], but also with the guidelines drawn up by the European Respiratory Society/American Thoracic Society[3] and the American College of Chest Physicians, and the Canadian Thoracic Society[4], all of which, after evaluating the evidence, recommend the use of mucolytics/antioxidants for the prevention of COPD exacerbations. Secondly, GOLD recommends the use of ICS in patients with blood eosinophil levels of 100–300 cells/μL who have at least 1 moderate exacerbation per year despite adequate bronchodilator therapy. GesEPOC, on the other hand, is more restrictive and recommends that the frequency and etiology of exacerbations, active smoking, and history or risk factors for pneumonia are considered in these patients before prescribing ICS.

Nevertheless, the most important differences between both documents lie in the way patients are classified for treatment initiation and follow-up. GesEPOC recommends classifying patients into 2 risk levels according to 3 variables: dyspnea level; exacerbations in the previous year; and lung function. High-risk patients are then classified into 3 phenotypes: non-exacerbator, eosinophilic exacerbator, and non-eosinophilic exacerbator. GOLD, in contrast, classifies patients into 4 categories, A–D, according to the frequency of exacerbations and the level of symptoms. If we omit lung function, low-risk patients according to GesEPOC would be equivalent to GOLD A, and high-risk non-exacerbators would be GOLD B. However, we believe that lung function is important because, for example, the same approach should not be taken in a GOLD B patient with an mMRC of 3 or a COPD Assessment Test (CAT) of 25 if their FEV_1 (%) is 30% or 65%: in the first case, maximum bronchodilation is clearly needed, but in the second, symptoms may not be purely due to respiratory causes, and other factors, such as comorbidities, may need to be investigated and treated. This and other considerations have led us to include FEV_1 in the treatment decision algorithm[5,6]. GesEPOC categorizes patients at high risk of exacerbation as eosinophilic or non-eosinophilic and recommends a single treatment alternative for each group: LABA/ICS or LABA/LAMA, respectively. GOLD, on the other hand, classifies exacerbators as C or D according to their symptom burden, meaning the most common group, D, is not offered a specific treatment, and LAMA, LABA/LAMA or LABA/ICS are recommended as first choice in these patients. In other words, classifying a patient as D is not associated with any particular treatment, but instead requires a subclassification to define the most appropriate option. In the GOLD D treatment schedule, the various options are indicated with asterisks: LABA/LAMA in highly symptomatic patients and LABA/ICS in individuals with >300 eosinophils/μl, while LAMA is indicated as the first choice for the rest. However, just as GOLD proposes 3 initial treatment options for the D category, a LAMA appears as the first treatment option for 3 of the initial GOLD categories, B, C, and D; this, in fact, could be true of all 4 categories, because "a bronchodilator" which could also be a LAMA is also recommended for category A. Taking this reasoning to the extreme, we might suggest that patients do not need to be classified as A, B, C, or D from the outset, since the administration of a LAMA covers treatment recommendations under all circumstances. The GesEPOC 2021 classification has been modified to make the recommendation more specific; in the previous edition, exacerbators were classified as emphysema or chronic bronchitis types, but the initial inhaled treatment was the same[7]. This classification has therefore been replaced by the 2 exacerbator groups, eosinophilic and non-eosinophilic, because this characteristic differentiates between the use or non-use of ICS.

DOI of original article: https://doi.org/10.1016/j.arbres.2021.04.009

☆ Please cite this article as: Miravitlles M. GesEPOC 2021 y GOLD 2021. ¿Más cerca o más lejos? Arch Bronconeumol. 2022;58:1–2.

URL: @MiravitllesMarc.

https://doi.org/10.1016/j.arbres.2021.04.030

For maintenance treatment, GOLD no longer uses the A–D classification; instead, it recommends several options depending on whether the underlying problem is dyspnea or exacerbations. It also recommends reviewing and adjusting treatment at each follow-up visit. GesEPOC maintains the same classification used for initial treatment and recommends a second therapeutic step for each patient type. Evaluation of treatable traits and second-line or non-inhaled therapy is only recommended in patients whose problems persist despite optimizing inhaled treatment. Furthermore, for the first time GesEPOC 2021 recommends assessing clinical control in COPD to evaluate the need for escalating or deescalating treatment[8,9].

In fact, the two different approaches to organizing treatment recommendations are simply two routes to the same destination. Following the recommendations in both documents to the letter, we will mostly, if not always, arrive at the same treatment; the diffierences lie in the path followed. The guidelines should attempt to strike a balance between clarity and rigor, while always avoiding ambiguous recommendations as far as possible. In summary, the treatment of COPD could boil down to 3 principles: 1) optimize bronchodilation to alleviate symptoms and reduce the risk of exacerbations; 2) add ICS if, despite bronchodilation, exacerbations persist and the patient is eosinophilic, and 3) if, despite optimal inhaled treatment, symptoms or exacerbations persist, evaluate treatable traits and the need for second-line treatments. The guidelines must convey this message as clearly and unequivocally as possible, without adding unnecessary complexity. Only the end users of the guidelines will be able to tell whether these documents have managed to help improve the treatment of COPD in this new decade[10].

Conflict of interests

Marc Miravitlles is the coordinator of GesEPOC, the Spanish COPD Guidelines. He has received honoraria for speaking engagements from AstraZeneca, Boehringer Ingelheim, Chiesi, Cipla, Menarini, Rovi, Bial, Sandoz, Zambon, CSL Behring, Grifols and Novartis; consultancy fees from AstraZeneca, Boehringer Ingelheim, Chiesi, Ferrer, GlaxoSmithKline, Bial, Gebro Pharma, CSL Behring, Laboratorios Esteve, Ferrer, Mereo Biopharma, Verona Pharma, Spin Therapeutics, pH Pharma, Novartis, Sanofi and Grifols; and research grants from Grifols.

References

1. Miravitlles M, Calle M, Molina J, Almagro P, Gómez JT, Trigueros JA, et al. Spanish COPD guidelines (GesEPOC). 2021 Update on pharmacological treatment of stable COPD. Arch Bronconeumol. 2022;58:69–81.
2. Global Initiative for Chronic Obstructive Lung Disease. 2021 Global Strategy for Prevention, Diagnosis and Management of COPD. GOLD; 2021. Available from: https://goldcopd.org/2021-gold-reports/ [Accessed 6 April 2021].
3. Wedzicha J, Calverley P, Albert R, Anzueto A, Criner G, Hurst J, et al. Prevention of COPD exacerbations: an European Respiratory Society/American Thoracic Society (ERS/ATS) guideline. Eur Respir J. 2017;50:1602265.
4. Criner GJ, Bourbeau J, Diekemper RL, Ouellette DR, Goodridge D, Hernandez P, et al. Prevention of acute exacerbations of COPD: American College of Chest Physicians and Canadian Thoracic Society Guideline. Chest. 2015;147:894–942.
5. Cabrera López C, Casanova Macario C, Marín Trigo JM, de-Torres JP, Torres RS, et al. Prognostic validation using GesEPOC 2017 severity criteria. Arch Bronconeumol. 2019;55:409–13.
6. Golpe R, Suárez-Valor M, Veiga-Teijeiro I, Veres-Racamonde A, Pérez-de-Llano LA. Should lung function be included in the risk stratification of chronic obstructive pulmonary disease proposed by GesEPOC? Arch Bronconeumol. 2019;55:436–7.
7. Miravitlles M, Soler-Cataluña JJ, Calle M, Molina J, Almagro P, Quintano JA, et al. Spanish COPD guidelines (GesEPOC) 2017. Pharmacological treatment of stable chronic obstructive pulmonary diseare. Arch Bronconeumol. 2017;53:324–35.
8. Soler-Cataluña JJ, Alcázar B, Miravitlles M. Clinical control in COPD: a new therapeutic objective? Arch Bronconeumol. 2020;56:68–9.
9. Miravitlles M, Sliwinski P, Rhee CK, Costello RW, Carter V, Tan JHY, et al. Changes in control status of COPD over time and their consequences: a prospective international study. Arch Bronconeumol. 2021;57:122–9.
10. Ancochea J, Soriano JB. COPD in Spain at the start of a new decade. Arch Bronconeumol. 2021;57:1–2.

Marc Miravitlles

Servicio de Neumología, Hospital Universitari Vall d'Hebron, Vall d'Hebron Institut de Recerca (VHIR), Vall d'Hebron Barcelona Hospital Campus, Centro de Investigación Biomédica en Red de Enfermedades Respiratorias (CIBERES), Barcelona, Spain

E-mail address: marcm@separ.es