Was Another Consensus Document on Treating Exacerbations of Chronic Obstructive Pulmonary Disease Needed?

To the editor: Within a short period of time 2 consensus documents have been published on how to treat exacerbations of chronic obstructive pulmonary disease (COPD). The first, published in the year 2002 in this journal, was signed by the Spanish Society of Pulmonology and Thoracic Surgery (SEPAR), the Spanish Society of Chemotherapy (SEQ), and the Spanish Society of Family and Community Medicine (semFYC).[1] The second, published in December 2002 in *Revista Española de Quimioterapia* and in June 2003 in this journal,[2] was signed by 5 scientific societies: SEPAR, SEQ, the Spanish Society of Emergency Medicine (SEMES), the Spanish Society of General Medicine (SEMG), and the Spanish Society of Rural and General Medicine (SEMERGEN). Our surprise on reading both the justification for this second consensus document and some of its contents has prompted us to write this letter. Was a second document really needed?

In this letter we focus on the recommended regimens for treating infectious exacerbations of mild to moderate COPD. There is no question about treatment in cases of severe COPD when there is suspected infection by *Pseudomonas aeruginosa* and associated comorbidity, such as ischemic heart disease or heart failure. In these cases the consensus document explains its recommendations clearly.

In the first place, it is not true that there was a 3-year gap between the 2 publications: in fact little over a year had

passed. The second consensus document continues to rely on the criteria of Anthonisen et al[3] for deciding on antibiotic treatment for mild exacerbations of COPD, citing that study to establish the indications for antibiotic treatment even in such cases, although there is very little supporting evidence. It is true that the benefits of antibiotic treatment were made clear in the study of Antonisen et al, in which patients with moderate to severe COPD—the mean forced expiratory volume in the first second of the patients enrolled in this study was 33.9%±13.7%—progressed better with antibiotic therapy than with placebo if the exacerbation caused at least 2 key symptoms. Since then it has been accepted that the presence of at least 2 of "Anthonisen's criteria" was sufficient to indicate the need for antibiotic treatment of the exacerbation. However it should be made clear that the validity of these criteria has only been established in hospital patients with moderate to severe COPD and never in ambulatory patients with mild to moderate COPD who comprise the majority of those treated by primary care physicians.[3] The benefits of antibiotics in exacerbations of COPD have been confirmed in seriously ill patients in intensive care units, who have been shown to have a decreased risk of developing pneumonia and a lower death rate than patients treated with placebo.[4] Unfortunately there are very few studies of patients with mild COPD that compare antibiotic therapy with placebo and the benefits of antimicrobial treatment have never been demonstrated.

Secondly, the consensus document still recommends a macrolide—either azithromycin or clarithromycin—as the treatment of choice although at the present time 35% of *Streptococcus pneumoniae* and 30% of *Haemophilus influenzae* strains in Spain are resistant to macrolides.[5] In the light of recently published literature on treatment failure in patients with community-acquired pneumonia receiving macrolide therapy, macrolides should be reserved for those infectious processes where they are considered the first line of treatment.[6] We therefore think that macrolides should not be recommended for treatment of COPD exacerbations. Lastly, the consensus document recommends telithromycin, a new antimicrobial agent, for treating exacerbations of mild COPD. Telithromycin is named as second choice, after the combination of amoxicillin and clavulanic acid, and before respiratory fluoroquinolones. Although it is true that telithromycin is an antibiotic that is very active against *S pneumoniae,* its effect on *H influenzae*, the most frequently occurring microbe in COPD exacerbations, is less than that of the new fluoroquinolones. Furthermore it is a drug that has not been in use for very long. Its reliability should therefore be verified.

The authors of these consensus documents should take into account the rigor with which guidelines are followed. While there are many reasons why guidelines are not taken into account, it is important for primary care doctors to see them as being clinically relevant, useful in day-to-day health care, clear, based on evidence, and subject to scientific and technical scrutiny. According to these criteria antibiotic therapy in exacerbations of mild COPD is not justified.

C. Llor Vilà[a] and K. Naberan Toña[b]
[a]Member of the General Practice Respiratory Infections Network (GRIN), World Organization of Family Doctors (WONCA).
[b]Member of the Respiratory Group in Primary Care (GRAP).

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