

diagnosis on hospital admission lists and is omnipresent in the differential diagnosis of breathing difficulties in middle-aged and older adults who present themselves at emergency departments. Therefore, it is particularly surprising that, unlike in other diseases (respiratory or otherwise), doctors responsible for the initial assessment of these patients are not equipped with a scale to facilitate the recognition or standardization of severity criteria when faced with the exacerbation of this disease, which is also associated with relatively heterogeneous clinical manifestations and additional examinations.<sup>1</sup>

How or when will we “speak the same language” to refer to the severity of patient X if our impression-based assessments are not supported by a more comprehensive, standardized, and reproducible method that also helps to plan subsequent treatment and available resources?

To the best of our knowledge, the only serious scale (BODE index<sup>2</sup>) validated for establishing prognosis in COPD was not designed for use as an everyday tool when correct diagnosis and decision-making are more critical. As every doctor knows, this initial assessment is the first link in a chain of accuracy or error during hospital stay.

In our opinion, the main difficulty lies, first of all, in the choice of variables to be included in a scale that aims to stratify these patients, since several factors seem to exert an influence. We are working on the design of a scale based on the results of a prospective, correlative study of a series of cases, carried out at Hospital Gustavo Aldereguía Lima in the province of Cienfuegos, Cuba.

The study, which ended in 2004 and included data covering all of 2003, analyzed the patient population admitted to the departments of internal medicine, geriatrics, and intensive care with a diagnosis of moderate or severe COPD exacerbated by respiratory infection (n=174). A questionnaire, which included the analysis of 73 clinical and paraclinical variables, was administered on arrival at the emergency department, and the progress of all the patients was subsequently monitored in the appropriate department. A univariate and multivariate analysis was then used to compare these variables in patients who survived and those who died. The following variables were independent risk factors for death due to COPD: age 65 years or older; resting heart rate higher than 100 beats/min; respiratory rate of at least 30 breaths/min; altered mental status; pH under 7.35 in arterial blood gas analysis; bilateral inflammatory lesions in chest x-rays; presence of P pulmonale or right axis deflection in the electrocardiogram; and the need for mechanical ventilation upon arrival in hospital.

It still remains to be seen whether these 8 variables will be able to answer the question of how and when we can admit patient X to a specific hospital department. Will we bring order to chaos or bring chaos to order? Only time and statistics will have the last word.

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**Prognostic Stratification in Patients With Exacerbated COPD Requiring Hospitalization: Seeing Through the Smoke**

**To the Editor:** Chronic obstructive pulmonary disease (COPD) figures as a frequent