

histopathological examination of a lobectomy sample showed congested lung tissue. The increase in venous pressure in the pre-stenotic zone would explain the lung tissue congestion and the risk of bleeding at the level of the mucosa in this area. In our patient, the image observed initially on the chest CT scan (Fig. 1A) appears to correspond to oedema and peribronchovascular fibrosis secondary to congestion due to thrombosis of the vein. This radiological finding may help to understand the pathophysiology a little more, and serve as a reference to help other clinicians to support the diagnosis of this entity.

Pulmonary vein ablation is a relatively safe procedure, although it is not free of complications. Among the late complications of this procedure are: cardiac tamponade, pulmonary vein stenosis, embolisms, vascular complications, phrenic nerve lesion, gastro-oesophageal fistula and gastric hypomotility secondary to lesion of the vagus nerve at peri-oesophageal level. All these complications, although rare, should be included in the differential diagnosis of unexplained symptoms in patients who have undergone pulmonary vein ablation in the past.

Pulmonary vein stenosis, although it presents asymptotically in most cases,<sup>4</sup> can manifest, as well as with haemoptysis, as dyspnoea on exertion, cough, chest pain or repeated infections,<sup>5</sup> which appear between 2 and 5 months after the procedure. For this reason, it is important to be aware of this complication, and to suspect it when these symptoms are present, in order for its early diagnosis and correction.

The therapeutic option in these patients is balloon angioplasty, with or without stent placement. At present, there are no definitive data that suggest that stenting obtains better results than balloon dilation alone.<sup>6</sup> In our patient, we initially opted for isolated angioplasty, although given the serious clinical repercussions, it was finally decided to place a stent in a second procedure.

Regardless of the therapeutic procedure chosen, and despite the high re-stenosis rate, recent studies show that early intervention is recommended in symptomatic patients.<sup>6</sup> In the case of asymptomatic patients, the treatment appears to show benefits, although the indication is not as clear.

Our patient's subsequent progress to date has been favourable, with no new episodes of haemoptysis and remission of the dyspnoea on exertion.

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## GesEPOC Guidelines and Elderly Patients<sup>☆</sup>

### *Guía GesEPOC y pacientes ancianos*

*To the Editor,*

I would like to congratulate all the professionals involved in developing the GesEPOC guidelines [Spanish COPD guidelines] for their excellent review and recommendations.<sup>1</sup> However, I sadly have difficulties in extrapolating their conclusions to the type of patient I usually see in Geriatric Departments, even though one of the most common diagnoses encountered there is chronic obstructive pulmonary disease (COPD) or its respective exacerbations. In fact, it is surprising that patients over the age of 80 were excluded from one of the largest studies on the prevalence of COPD in Spain,<sup>2</sup> when all studies indicate that it is one of the most significant and common diseases in the elderly, and equally surprising is that elderly patients are hardly mentioned in the guidelines.

Since interpretation in multimorbid patients is a highly complex task, elderly populations are routinely excluded from trials in numerous disciplines, and the evidence obtained from young populations in a generally better state of health is taken as valid for older populations. However, in the case of COPD, extrapolating

the evidence from the younger population has a series of important limitations.

From a diagnostic point of view, for example, some patients may present deafness, impaired vision or sarcopenia (among other limitations), causing difficulties in the correct performance and, as a result, the correct interpretation of spirometry tests. Functional or cognitive deficits can make complex tests, or even something as simple as the 6-min-walk test, difficult to perform and interpret. Most clinical guidelines have numerous limitations, since they do not evaluate the elderly patient's wide range of needs, and the evidence obtained from these guidelines habitually underestimates the prevalence of side effects, multimorbidity and polypharmacy, as well as the functional, cognitive and social aspects, and does not reflect the clinical reality.<sup>3–5</sup> From a treatment point of view, special consideration must be given to the iatrogenic effects that can occur in already polymedicated patients, since many of the drugs regularly used in COPD can have significant side effects in the elderly. In addition, the incorrect administration of inhaled therapies can lead not only to possible poor treatment compliance but also to poorer results from conventional treatments. Given the wide heterogeneity of this population, specific guidelines adapted and stratified according to grades of frailty, such as those already beginning to appear for some diseases like diabetes, are required.<sup>6</sup>

Although the new clinical practice guidelines in the treatment of patients with COPD (GesEPOC) are very useful, for these reasons I feel that they are limited in their use in elderly patients and

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could be substantially improved in this sector of the population. Despite the obvious difficulties in dealing with all aspects of COPD universally, assigning a section exclusively to the elderly patient would provide significant benefits for their clinical management. For future editions, I would urge the authors to call on professional geriatric societies to contribute with their complementary point of view.

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