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Letters to the Editor

In Response to: Martínez-Velilla N. GesEPOC Guidelines and Elderly Patients☆

Respuesta a: Martínez-Velilla N. Guía GesEPOC y pacientes ancianos

To the Editor:

We welcome the comments on GesEPOC guidelines by Martínez-Velilla, and we agree with his assessment of the difficulty in diagnosis and treatment of COPD in the elderly patients.[1] As noted in his letter, the prevalence of COPD in our country is known to increase with age and smoking history. Despite this, the mean age of patients included in clinical trials is typically around 65 years, with underrepresentation of older patients. Moreover, aging causes a number of functional and anatomical changes that partly resemble those produced by COPD itself, which has led some authors to consider the disease as accelerated lung aging.[2] Another aspect to consider is that the diagnostic criterion of bronchial obstruction based on an FEV_1/FVC ratio <0.7 leads to overdiagnosis in the elderly patients.[3] For this reason, the GesEPOC guidelines recommend referring to the lower limit of normal in patients older than 70 years.[4]

We also agree with the author on the greater difficulty of performing some explorations in this population. Although age alone does not preclude spirometric quality, it does increase the time required for its completion. In patients with cognitive impairment, the Mini-Mental State Test can be used to predict which patients will successfully perform spirometry.[5] In any case, spirometry is currently essential for the diagnosis of COPD, although its performance in the elderly patients can be simplified with the use of the FEV_1/FEV_6 ratio.[6] Regarding the walking test, GesEPOC indicates that it should be substituted by the number of previous severe exacerbations (BODEx index)[4] when it cannot be performed.

It is also true that most clinical practice guidelines are focused on specific diseases, and strict application in patients with multimorbidity may often be ineffective and even counterproductive, as iatrogenesis may be an issue. This stems from the lack of solid scientific evidence (necessary in clinical practice guidelines) on the simultaneous management of multiple complex chronic diseases, and means that treatment goals must be adapted to therapeutic priorities and patients' wishes. Guidelines will never be able to encompass all the scenarios encountered in everyday clinical practice and cannot (nor do they aim to) replace the clinical judgment of each physician with his/her patient. Thus, in the case of COPD, recent studies have identified as many as 36 different comorbidities occurring at a rate of over 5%.[7] These can present in many combinations in patients, leading to a possibly infinite variety of situations that no guidelines will ever be able to address. We believe that the recommendations in the guidelines, with the logical and necessary adaptations to the particular conditioning factors of individual patients, are applicable to most of the population with the disease. GesEPOC also includes aspects that are not fully addressed in other guidelines, such as respiratory rehabilitation during exacerbation, a chapter on comorbidities and another on palliative treatment. However, we recognize the need for new adaptations and collaborative efforts in subsequent revisions of the guidelines to which fellow geriatricians can make important contributions.

References

1. Martínez-Velilla N. GesEPOC guidelines and elderly patients. Arch Bronconeumol. 2013;49:367–8.
2. Ito K, Barnes PJ. COPD as a disease of accelerated lung aging. Chest. 2009;135:173–80.
3. García-Río F, Soriano JB, Miravitlles M, Muñoz L, Duran-Tauleria E, Sánchez G, et al. Overdiagnosing subjects with COPD using the 0.7 fixed ratio: correlation with a poor health-related quality of life. Chest. 2011;139:1072–80.
4. Miravitlles M, Soler-Cataluña JJ, Calle M, Molina J, Almagro P, Quintano JA, et al. Spanish COPD guidelines (GesEPOC). Pharmacological treatment of stable COPD. Arch Bronconeumol. 2012;48:247–57.
5. Allen SC, Yeung P. Inability to draw intersecting pentagons as a predictor of unsatisfactory spirometry technique in elderly hospital inpatients. Age Ageing. 2006;35:304–6.
6. Bellia V, Sorino C, Catalano F, Augugliaro G, Scichilone N, Pistelli R, et al. Validation of FEV_6 in the elderly: correlates of performance and repeatability. Thorax. 2008;63:60–6.
7. Divo M, Cote C, de Torres JP, Casanova C, Marin JM, Pinto-Plata V, et al. Comorbidities and risk of mortality in patients with chronic obstructive pulmonary disease. Am J Respir Crit Care Med. 2012;186:155–61.

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