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Editorial

What was the Impact of the Spanish COPD Guidelines (GesEPOC) and how can They be Improved?☆

¿Qué ha supuesto la Guía Española de la EPOC (GesEPOC) y cómo puede mejorar?

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Before reading any further, the reader should be advised that the author of this editorial has a clear intellectual conflict with its contents, as he has collaborated intensively in drawing up the Spanish COPD Guidelines (GesEPOC).[1] Therefore, it is highly likely that the opinions expressed below are biased by a view conditioned by the guideline drafting process. Nevertheless, this view does not prevent the author from seeing, hearing and valuing the sincere, although not always favourable, opinions of many colleagues. If this introduction has not discouraged the reader, I hope that the time spent reading this editorial will be worthwhile.

GesEPOC does not stand in opposition to anyone or anything, but follows the trend set by a very relevant article published in 2010.[2] It is true that GesEPOC sought to innovate, based on the widely accepted concept that we had to go beyond the forced expiratory volume in the first second (FEV_1), and that types (or phenotypes) of patients who share characteristics and responses to treatments had to be identified.[3] Innovation is always a risk, but we thought that sufficient evidence had been gathered to justify launching a proposal of this type. Almost simultaneously, the Global Obstructive Lung Disease (GOLD) initiative also launched its proposal to go beyond the FEV_1, albeit differently.[4] The concurrence of these different ways of addressing the same reality has generated considerable debate and, sincerely, I believe that COPD in general has benefitted, even at the risk of adding to the confusion. There is no doubt that the GOLD document is a global reference, but it is not unanimously accepted[5]; GesEPOC is, or should be, the reference guide in Spain, but it is also true that it is not unanimously accepted nationally.

What has publication of the Spanish COPD guidelines meant? We can list a number of answers: (a) recognition and dissemination of the complexity of COPD. There is not one COPD, but several, and it is the clinician's responsibility to recognize these different profiles or phenotypes; (b) it has encouraged multidimensional evaluation of COPD severity with the BODE/BODEx indices; (c) dissemination of the mixed COPD-asthma phenotype (better known as asthma-COPD overlap syndrome [ACOS]); (d) it has pioneered the inclusion of highly topical concepts, such as withdrawal of inhaled corticosteroids, long-term antibiotic treatment, and end stage COPD treatment; (e) it has encouraged collaboration among professionals dedicated to the care of COPD patients by involving 10 scientific societies; (f) it has contributed to raising awareness of COPD at all levels. Countless news articles, training courses, conferences, scientific articles and debates have arisen following publication of the guidelines; (g) it has helped disseminate the image of SEPAR and Archivos de Bronconeumología. GesEPOC is linked to SEPAR, and both within Spain and especially, beyond our borders, GesEPOC has helped to give an image of SEPAR as an innovative society at the forefront of science. All clinicians involved in COPD care are aware of the Spanish guidelines, as proven by the fact that it has inspired other national clinical guidelines, such as those of the Czech Republic[6] and Finland,[7] which have openly adopted some of its recommendations. The contribution of the guidelines to the impact factor and prestige of our journal should also be highlighted, as the GesEPOC was by far the most extensively cited article of the year in which it was published.

Nevertheless, we cannot ignore aspects that need improvement, some of which are detailed below, although this is not an exhaustive list and is presented from a personal viewpoint: (a) a better definition of the exacerbator phenotype with emphysema is needed. This was initially considered a phenotype "by exclusion" to identify a patient with COPD, a frequent exacerbator, without ACOS, and not accompanied by chronic bronchitis.[3] It would be difficult to find any patient with these characteristics who did not present some emphysema lesion and, for this reason, it was called exacerbator with emphysema. However, it should be acknowledged that a diagnosis of emphysema has implications, and appropriate techniques are available for this purpose and should be recommended; (b) better definition of ACOS. Using the criteria in the guidelines, only 5% of patients with COPD due to smoking were diagnosed with ACOS.[8] This is not exclusive to GesEPOC, as the recent GINA-GOLD document did not provide a precise definition either.[9] It is a topic on which we are working intensely, and I am sure that in the near future results will be obtained that are applicable to clinical practice[10]; (c) the classification of severity should be simplified. The inclusion of the BODE/BODEx indices and the alternative severity

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assessment have been shown to add complexity to patient evaluation. Instead of 5 severity levels, perhaps one initial treatment should be defined per phenotype and adjusted according to a different concept, such as disease control,[11] and (d) dissemination and implementation should be improved. This aspect is also common to all guidelines, and there are no universally applicable solutions.

It is difficult to make predictions, but I agree with Agustí,[12] in that the future treatment of COPD will be guided by a number of "treatable factors" that will be grouped differently in each patient, and that this will lead to a much more personalized approach. This would involve systematizing what in fact we clinicians do in our daily practice: using all our senses to gather data and information and assimilating these with our knowledge and experience until we finally arrive at the best treatment for each patient. However, until such time as guidelines or support systems that can fulfil all these functions become available, the approach to treatment offered by GesEPOC represents a step towards more individualized treatment of COPD.

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References

1. Miravitlles M, Soler-Cataluña JJ, Calle M, Molina J, Almagro P, Quintano JA, et al. Spanish Guideline for COPD (GesEPOC). Update 2014. Arch Bronconeumol. 2014;50 Suppl. 1:S1–16.
2. Han MK, Agusti A, Calverley PM, Celli BR, Criner G, Curtis JL, et al. Chronic obstructive pulmonary disease phenotypes: the future of COPD. Am J Respir Crit Care Med. 2010;182:598–604.
3. Miravitlles M, Calle M, Soler-Cataluña JJ. Clinical phenotypes of COPD. Identification, definition and implications for guidelines. Arch Bronconeumol. 2012;48:86–98.
4. Vestbo J, Hurd SS, Agusti AG, Jones PW, Vogelmeier C, Anzueto A, et al. Global strategy for the diagnosis, management and prevention of chronic obstructive pulmonary disease: GOLD executive summary. Am J Respir Crit Care Med. 2013;187:347–65.
5. Zysman M, Patout M, Miravitlles M, van der Molen T, Lokke A, Hausen T, et al. COPD and perception of the new GOLD document in Europe. Workshop from the Société de pneumologie de langue française (SPLF). Rev Mal Respir. 2014;31:499–510 [in French].
6. Koblizek V, CHlumsky J, Zindr V, Neumannova K, Zatloukal J, Zak J, et al. Chronic obstructive pulmonary disease: official diagnosis and treatment guidelines of the Czech Pneumonogical and Phthisiological Society: a novel phenotypic approach to COPD with patient oriented care. Pap Med Fac Univ Palacky Olomouc Czech Repub. 2013;157:189–201.
7. Kankaanranta H, Harju T, Kilpeläinen M, Mazur W, Lehto JT, Katajisto M, et al. Diagnosis and pharmacotherapy of stable chronic obstructive pulmonary disease: the Finnish Guidelines. Guidelines of the Finnish Medical Society Duodecim and the Finnish respiratory Society. Basic Clin Pharmacol Toxicol. 2015;116:291–307.
8. Golpe R, Sanjuán López P, Cano Jiménez E, Castro-Añón O, Pérez de Llano LA. Distribution of clinical phenotypes in patients with chronic obstructive pulmonary disease caused by biomass and tobacco smoke. Arch Bronconeumol. 2014;50:318–24.
9. GINA-GOLD. Diagnosis of disease of chronic airflow limitation: asthma, COPD and asthma-COPD overlap syndrome (ACOS) [consultado 5 Ene 2015]. Disponible en: http://www.goldcopd.org/asthma-copd-overlap.html.
10. Barrecheguren M, Esquinas C, Miravitlles M. The asthma COPD overlap syndrome (ACOS). Opportunities and challenges. Curr Opin Pulm Med. 2015;21:74–9.
11. Soler-Cataluña JJ, Alcazar B, Miravitlles M. The concept of control of COPD in clinical practice. Int J Chron Obst Pulm Dis. 2014;9:1397–405.
12. Agustí A. The path to personalised medicine in COPD. Thorax. 2014;69:857–64.