

Editorial

 GOLD in 2017: A View From the Spanish COPD Guidelines (GesCOPD)[☆]


GOLD en 2017: una visión desde la Guía Española de la EPOC (GesEPOC)

 Marc Miravittles,^{a,*} Juan José Soler-Cataluña^b
^a Servicio de Neumología, Hospital Universitari Vall d'Hebron, Barcelona, Spain

^b Servicio de Neumología, Hospital Arnau de Vilanova-Lliria, Valencia, Spain

Last November, we saw the publication of the 2017 version of the Global Initiative for Chronic Obstructive Lung Disease strategy (GOLD),¹ yet another step in a process that began when the first document was published in 2001. GOLD has contributed significantly to putting chronic obstructive pulmonary disease (COPD) on the map of diseases affecting global public health, and has helped standardize aspects such as the definition, diagnostic criteria, and general therapeutic approach to COPD. Until the 2011 version, stratification of COPD severity or risk was based on lung function, and this parameter was used to guide pharmacological treatment. This version of GOLD changed the approach to patient evaluation, and recognized that factors other than forced expiratory volume in 1 s (FEV₁) were equally or even more important when selecting treatment, including symptoms and risk level determined according to the frequency of exacerbations. These factors were organized in a grid that defined 4 categories identified by the letters A–D according to the level of symptoms and risk.² This was an important step in the path toward personalized treatment, but problems soon emerged. Basically, the main issues were that there was more than 1 determinant for each axis in the grid, and a patient classified as C or D according to poor lung function was very different from one classified as C or D due to frequent exacerbations and who, as such, needed a different type of treatment. Moreover, several studies found that depending on whether the modified Medical Research Council (mMRC) dyspnea scale or the COPD Assessment Test (CAT) was used, the same patient could be classified in different categories,³ and that patients classified as B (low risk) had higher mortality than patients classified as C (high risk).⁴ These inconsistencies prompted the review that led to the new 2017 version. Some of the most important changes in this new version are that FEV₁ has been excluded from the treatment grid and proposals are given for treatment intensification and tapering in each of the categories A–D.¹

From the point of view of the official clinical practice guidelines for the treatment of COPD in Spain (GesEPOC),⁵ it is worth remembering first and foremost that GOLD is not a clinical guideline, but rather presents strategies that countries can adapt to their own real-world situation. Right from the start, GesEPOC included a number of GOLD principles, but produced a different suite of phenotype-based recommendations, based on an evaluation of the evidence and a multidisciplinary approach.⁵ Phenotypes, for example, were defined according to the descriptions previously published by some of the authors of the GOLD document.⁶ Despite the initial portrayal of phenotypes as “the future of COPD” and the numerous studies that emerged in the following years, the word “phenotype” is still absent from GOLD 2017. The underlying meaning of the concept is, of course, more important than the actual word, and in this respect, the current GOLD grid is now very similar to that of GesEPOC, to the extent that both share the same “y” axis that divides patients into exacerbators and non-exacerbators; the “x” axis, however, is still different. GOLD 2017 once again classifies patients according to mMRC or CAT, while the GesEPOC uses the standard clinical phenotypes: emphysema, chronic bronchitis, or asthma-COPD overlap syndrome (ACOS). For the treatment of patients in the D group, GOLD includes drugs such as roflumilast, but adds an explanation that they can be used when the patient presents cough and expectoration (chronic bronchitis phenotype), and even mentions the preference for using inhaled corticosteroids (ICS) combined with bronchodilators in patients with ACOS or eosinophilia. In fact, it is surprising that ACOS is not included in the treatment scheme, since in 2014, GOLD, in collaboration with the Global Initiative for Asthma (GINA), published a long document on ACOS, which even included therapeutic recommendations.⁷ Up to 20% of patients with COPD may have ACOS, but in GOLD 2017 its presence has been reduced to only a few lines in the whole document.

The new GOLD grid should be welcomed as an attempt to simplify the issue; however, it does not address the real complexity of the disease. The examples of ICS, roflumilast, azithromycin, and mucolytics underline the weaknesses of the new GOLD classification, since these drugs cannot be indicated according to the patient's mMRC or CAT scores, and instead, the phenotypes of patients who will respond to these therapies must be identified⁸; this is the approach described by GesEPOC. Nor should these drugs be reserved for group D, since they may be needed by some group C patients who, likewise, meet the indications for treatment.

[☆] Please cite this article as: Miravittles M, Soler-Cataluña JJ. GOLD en 2017: una visión desde la Guía Española de la EPOC (GesEPOC). Arch Bronconeumol. 2017;53:89–90.

* Corresponding author.

E-mail address: mmiravittles@vhebron.net (M. Miravittles).

In contrast to GesEPOC, the GOLD gives less attention and therapeutic importance to the evaluation of future risks; only the frequency of previous exacerbations is considered and neither FEV₁ nor multidimensional scales, such as BODE etc., are taken into account.

In addition to the simplification of the grid, GOLD and GesEPOC have also come closer in other areas, such as the reference in GOLD 2017 to treatment with macrolides, the mention of withdrawal of ICS, the use of inhaled antibiotics in bronchiectasis associated with COPD, and palliative or end-of-life care, points that already appeared in the original 2012 version of GesEPOC.⁵

In conclusion, the differences between the GOLD and GesEPOC classifications of patients as exacerbators or non-exacerbators are clearly reducing, although using the mMRC or the CAT in exacerbators (C or D) is not, in our opinion, useful for identifying the optimal preventive treatment.⁹ Nevertheless, the initial gap between the two proposals is gradually closing.¹⁰ Perhaps one day differences will be reduced to a mere question of terminology rather than of concepts.

Conflict of Interest

The authors declare that they do not have any economic conflicts of interests with regard to this article, but as authors of the GesEPOC guidelines, they do have an intellectual conflict of interest.

References

1. Global Strategy for the Diagnosis, Management and Prevention of COPD, Global Initiative for Chronic Obstructive Lung Disease (GOLD) 2017. Available from: <http://goldcopd.org> [accessed 27.12.16].
2. Vestbo J, Hurd SS, Agustí 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.
3. Casanova C, Marín JM, Martínez-González C, de Lucas-Ramos P, Mir-Viladrich I, Cosío B, et al., COPD History Assessment In Spain (CHAIN) Cohort. New GOLD classification: longitudinal data on group assignment. *Respir Res.* 2014; 15:3.
4. Casanova C, Marín JM, Martínez-González C, de Lucas-Ramos P, Mir-Viladrich I, Cosío B, et al., COPD History Assessment in Spain (CHAIN) Cohort. Differential effect of modified Medical Research Council dyspnea, COPD assessment test, and Clinical COPD Questionnaire for symptoms evaluation within the new GOLD staging and mortality in COPD. *Chest.* 2015;148:159–68.
5. Miravittles 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.
6. Han MK, Agustí 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.
7. Global Strategy for Asthma Management and the Prevention and the Global Strategy for the Diagnosis, Management and Prevention of Chronic Obstructive Pulmonary Disease. Diagnosis of diseases of chronic airflow limitation: asthma COPD and Asthma-COPD Overlap Syndrome (ACOS); 2014. Available from: <http://www.goldcopd.org/uploads/users/files/AsthmaCOPDOverlap.pdf> [accessed 27.12.16].
8. Miravittles M, D'Urzo A, Singh D, Kobliczek V. Pharmacological strategies to reduce exacerbation risk in COPD: a narrative review. *Respir Res.* 2016; 17:112.
9. Santos S, Marín A, Serra-Batlles J, de la Rosa D, Solanes I, Pomares X, et al. Treatment of patients with COPD and recurrent exacerbations: the role of infection and inflammation. *Int J Chron Obst Pulm Dis.* 2016;11:515–25.
10. Izquierdo Alonso JL. The differences between GesEPOC and GOLD. *Arch Bronconeumol.* 2016;52:453–4.