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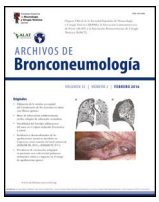

Editorial

The Rationale for GesEPOC in our Environment☆

El porqué de la GesEPOC en nuestro entorno

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Chronic obstructive pulmonary disease (COPD) is one of the most important respiratory diseases, not only because it is both highly prevalent and highly underdiagnosed[1] (issues that still need to be addressed by pulmonologists), but also because of its enormous impact on quality of life and morbidity and mortality, particularly during exacerbations.[2] In the 6 years since the Global Obstructive Lung Disease (GOLD) proposal was published in 2011, the criteria used to determine treatment have evolved rapidly. After a long period of little change, GOLD introduced the concept of evaluating dyspnea, quality of life, and risk of exacerbation, measured by lung function and the number of moderate-severe exacerbations in the previous year,[3] to determine patient treatment.

The limited choice of drugs available until that time probably contributed to the previous lack of progress, but since then new bronchodilators, and in particular, combinations of these agents have appeared, and new studies focusing on the role of dual bronchodilation[4] and the combination of long-acting beta-2 agonists with inhaled corticosteroids (LABA + ICS)[5,6] have been published, dramatically changing the whole therapeutic framework to which we were bound for years.

Another factor that has definitively contributed to this rapid progress, and to the positioning of these molecules, is the introduction of COPD phenotypes.[7] Spanish pulmonology has been a pioneer in this respect, thanks to the publication in 2012 of the Spanish COPD guidelines (GesEPOC),[8] which included clinical phenotypes in therapeutic regimens. This game-changing approach was later taken up by other countries in their national guidelines.

GesEPOC introduced not only the concept of clinical phenotypes, but also provided a more complete evaluation of severity based on multidimensional scales (BODE or BODEx), leading to more personalized COPD treatment, although the downside was that patient management became more complex.

The complexity of applying these multidimensional scales for evaluating disease severity is clearly reflected in the analysis of the results of the EPOCONSUL study,[9] a clinical audit of over 4500 COPD outpatients conducted by Spanish pulmonologists. In this audit of almost 18,000 data entries, only 12.4% of respondents used BODE and 6.2% used BODEx to determine the severity of their COPD patients, compared to 81.3% who continued to use FEV_1, as they had been doing before GesEPOC and GOLD 2011.

Some criticism also emerged regarding the criteria required for classification of phenotypes. One example is the mixed phenotype or asthma COPD overlap syndrome (ACOS), which sometimes requires sputum eosinophilia determinations for diagnosis; this technique is not readily available in most centers, despite being proven in the literature to be one of the most consistent criteria.[10] The difficulty of classifying patients according to their phenotype is also highlighted in the EPOCONSUL study, which found that phenotype classification was achieved in just under half of all patients.[9]

Although the objective of the GesEPOC guidelines is more efficient COPD care in our setting, no objective information is available on the real impact of the proposal. It seems that specific tools need to be developed in the future to explore these issues, and in particular the difficulties reported in implementing the guidelines.

The new, revised and substantially altered GesEPOC guidelines[11] are published in this edition of our journal. One of the major changes is the simplified diagnosis of ACOS, with easily applied criteria based on current scientific evidence, requiring only clinical history, spirometry with bronchodilator challenge, and eosinophilia in peripheral blood,[12] features that will greatly facilitate patient classification, particularly in the primary care setting.

Another novel aspect is the stratification of patient risk. The complex classification of 5 severity stages based on multidimensional scales has been replaced by a simpler classification that differentiates “low-risk” patients, non-exacerbators according to GOLD 2017,[13] who have a modified Medical Research Council (mMRC) dyspnea grade 2 or less, and FEV_1 greater than 50%, and “high-risk” patients, frequent exacerbators according to GOLD 2017, who have FEV_1 less than 50% or mMRC dyspnea grade 3 or less. This classification simplifies the evaluation of the risk and treatment options, since low-risk patients will not need anti-inflammatory treatment and will only receive bronchodilators. The phenotype of high-risk patients will have to be identified, since the treatment of these patients will be selected according to whether they are non-exacerbators, ACOS, exacerbators with emphysema, or exacerbators with chronic bronchitis.

These are only some of the innovations that appear in the new GesEPOC, which will be analyzed in more detail after publication.

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There is little doubt that the publication of the GesEPOC was a watershed in the management of COPD in Spain, and that it has been very influential, even beyond our borders. Both pharmacological and non-pharmacological therapeutic management of COPD have progressed rapidly in recent years. An update of the GesEPOC guidelines, responding to criticisms and reflecting new evidence, was required. The new GesEPOC will no doubt be the subject of much debate and discussion, and opinions will be aired that will enrich our perception of the disease and help us to continue our progress toward our future goal: providing our patients with ever more personalized, better quality care.[14]

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