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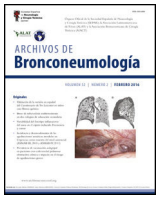

Editorial

Is the Social Component of chronic obstructive pulmonary disease a Treatable Trait?☆

El componente social de la enfermedad pulmonar obstructiva crónica: ¿un rasgo tratable de la enfermedad?

Alberto Fernández-Villar,* Sara Fernández-García, Cristina Represas-Represas

Grupo NeumoVigo I+i, Instituto de Investigación Sanitaria Galicia Sur (IISGS), Servicio de Neumología, Hospital Álvaro Cunqueiro, Vigo, Spain

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The World Health Organization (WHO) predicts that in the next few years chronic obstructive pulmonary disease (COPD) will become the third leading cause of death worldwide.[1] Prevalence will also increase due to not only the persistently high number of smokers, but more particularly to population aging and the longer survival times currently achieved.[1] Of all the respiratory diseases, COPD is probably the paradigm of chronicity, and proper management involves not only treating the lung disease and all its associated comorbidities, but also ensuring that the patient's most basic needs are met, and that their autonomy and ability to relate with their environment or community are maintained.[2] The limited evidence available suggests that the social situation of many of the COPD patients we see in our clinics and hospital wards is precarious.[3,4]

We are currently transitioning from escalating therapeutic management of patients with COPD to a more personalized approach that involves evaluating the treatable traits of the disease.[5]

In this paper, we hope to encourage professionals and health care managers to reflect on the social component of COPD, and suggest that it could be considered a treatable trait in the context of a more personalized and precise approach to medicine.

Firstly, a treatable trait must have clinical relevance, and thus be associated with specific health outcomes.[5] A large body of evidence suggests that several social factors, such an unstable economic situation, dependence for the most basic activities, and a lack of social and family support, result not only in a worse perception of health status, but also in longer hospital stays, more readmissions, and higher mortality.[6–10] The social component also has an impact on other key elements within a comprehensive treatment plan, such as adherence to pharmacological treatments and rehabilitation, smoking cessation, and psychological status.[2,10]

Secondly, a treatable trait must be identifiable and measurable.[5] Most COPD social dimension factors can be evaluated and stratified using generic and specific scales and questionnaires, and indeed, the use of these instruments is recommended in institutional COPD treatment protocols.[11] In both COPD and other chronic diseases, the capacity of many of these indexes and scales to predict events is similar or even superior to that of the clinical and demographic variables currently in use, such as age, degree of dyspnea or obstruction, and number of comorbidities.[8,9,12,13]

Finally, a treatable trait must, as its name suggests, be treatable.[5] An appropriate comprehensive plan that addresses social areas, such as improved accessibility and integration in the community, or care for patients that are dependent for the most basic activities of daily living, can be instrumental in improving health outcomes and the efficiency of care.[14,15]

In a recently published document, in which several experts discuss treatable traits, including pulmonary, extrapulmonary, behavioral, and lifestyle variables, references to social factors are minimal, and only include the family situation.[5]

Patients often take their concerns and problems to the only network they know, i.e., the healthcare system, because it is close-by, accessible, and trustworthy, even if they really need social rather than clinical help, and would be better managed through programs and perspectives that are not yet well defined or implemented.[2] Although the evidence is limited, inefficiency and waste in this area is probably very high.[7] A recently published study with a high readmission rate showed that less than 25% of patients had been seen by social services, despite unfavorable social profiles in

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* Corresponding author.
E-mail address: alberto.fernandez.villar@sergas.es (A. Fernández-Villar).

all dimensions.[4] The MAG-1 clinical audit found that only 20% of discharge reports for severe COPD exacerbation mentioned social issues.[16] Of particular concern in this regard are gender differences, as the social situation of women with COPD is much worse than that of men in terms of economic status and support.[4] In the follow-up of the SocioEPOC cohort, from which some data have now been published,[4,9] areas such as the family situation determined by the Gijon scale or dependence for basic activities assessed by the Barthel index are far better predictors of length of hospital stay, short-term and long-term readmissions, and mortality than many clinical variables. These instruments may need to be included in the validation of new predictive scales, as other authors have suggested.[12] Unfortunately, most likely due to a lack of awareness of the importance of this problem, these situations are often only detected when difficulties arise after a patient is discharged home after a hospital admission, or when the readmission rate is very high.[6,7]

As William Osler said almost 200 years ago, the good physician treats the disease; the great physician treats the patient who has the disease. In this respect, pulmonologists and other professionals who treat these patients must systematically evaluate the social situation of the patient in order to design the best plan of treatment and care in each particular case. Except for very specific situations, most hospitals and health areas will have to redefine how they currently provide health and social services, and begin to look towards new welfare models in the search for more proactive, continuous, integrated, efficient, and patient-centered care.

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