

Editorial

Clinical Guidelines in Asthma and Chronic Obstructive Pulmonary Disease: How Useful Are They in Clinical Practice? ☆



Guías clínicas en asma y enfermedad pulmonar obstructiva crónica: ¿cuál es su utilidad en la práctica clínica?

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Clinical practice guidelines (CPG) are systematically developed with the primary objective of helping clinicians and patients make decisions about the most appropriate healthcare in certain circumstances.¹ Another main objective of CPGs is to improve the quality of patient care by encouraging practitioners to use interventions with a proven benefit, while avoiding those that may be ineffective or even harmful to their patients. CPG recommendations also aim to reduce unnecessary variability and inequalities in clinical practice, influence public health policies, and empower patients.²

Chronic obstructive pulmonary disease (COPD) and bronchial asthma are the 2 most prevalent and resource-consuming respiratory diseases in Spain, and are the reason for most consultations by patients in primary care centers and specialized clinics. The development of CPGs for these 2 diseases, then, is a priority from both a clinical and a public health policy point of view.

Several reference documents are currently available in the area of COPD and bronchial asthma: for COPD, we have the Spanish COPD Guidelines (GesEPOC)³ and the Global Initiative for Obstructive Lung Disease (GOLD),⁴ more a World Health Organization-sponsored consensus document than a CPG, which proposes an international strategy for the diagnosis and treatment of this disease. For asthma, we have the Spanish Asthma Management Guidelines (GEMA)⁵ and the Global Initiative for Asthma (GINA),⁶ which is broadly similar to the GOLD in its approach. Each document has its particular characteristics and all are readily available to the scientific community.

However, despite the potential benefits of CPG adherence, these guidelines are not routinely used in clinical practice, or at least not extensively. This is true not only of respiratory diseases, but also applies to almost any chronic disease.

In COPD, the most recent data on adherence come from the EPOCONSUL study, a study undertaken by the COPD area of SEPAR that aimed to evaluate care of the COPD patient in respiratory medicine outpatient clinics. EPOCONSUL revealed that adherence to recommendations for COPD assessment and management (both GOLD and GesEPOC) is low in general, with CPG adherence rates of between 22% and 65%, depending on the aspect evaluated.⁷

With regard to CPG adherence in bronchial asthma, the degree of adherence to GINA guidelines is quite high with regard to the use of anti-inflammatory medication for the control of asthma and for the assessment and management of exacerbations, but deficiencies were observed in the implementation of self-care initiatives, disease control assessment, training in inhaled therapy, and the management of comorbidities in bronchial asthma.⁸

Although correct CPG adherence in COPD and bronchial asthma has not been shown to improve health outcomes such as mortality or hospitalization, sufficient evidence is available in other chronic and respiratory diseases, such as community-acquired pneumonia, to show that CPG adherence is associated with lower mortality, a lower rate of hospital admissions, and a lower incidence of side effects.⁹ A clear example of the benefit of CPG adherence is the MAHLER study, conducted by several European cardiology societies,¹⁰ in which adherence to treatment recommendations in congestive heart failure was associated with a decrease in hospital admissions for cardiovascular disease.

CPG adherence in the area of bronchial asthma and COPD must be encouraged and supported by regulatory bodies, scientific societies, and by the organizations involved in the management of these patients. However, the opinion of patients' associations and the difficulties of physicians in achieving adherence in the day-to-day management of their patients must be taken into account if we are to draw up CPGs that are easy to apply without skimping on robust evidence-based science. It seems clear that these issues will have to be more closely examined in coming years, and CPGs will have to be developed with the involvement of numerous stakeholders.

☆ Please cite this article as: Alcázar-Navarrete B, Castellano Miñán F, Romero Palacios PJ. Guías clínicas en asma y enfermedad pulmonar obstructiva crónica: ¿cuál es su utilidad en la práctica clínica? Arch Bronconeumol. 2018;54:117-118.

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Furthermore, new consensus documents that call for changes in well-established clinical practices should be promoted with caution, and every effort should be made to obtain the backing of the largest possible number of scientific societies and the collaboration of patients' associations and regulatory bodies. To avoid confusion, a profusion of proposals that do not reflect substantial changes must be avoided. One of the fundamental factors to be taken into account when proposing new CPGs is to ensure that they guarantee the safety of both the patient and the physician, and form a legal and scientific framework of reference.

In short, CPGs help standardize the clinical care offered to patients, by setting up a framework of reference for all stakeholders involved in the provision of healthcare. CPG adherence usually provides patients with the best health outcomes in the most efficient manner possible. It is essential, then, that CPGs are circulated and implemented so that optimal patient care can be offered, regardless of the setting.

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