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What Prevents Early Diagnosis, Good Prognosis, and Quality of Life in COPD?

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Experts constantly lament the global increase in COPD but unfortunately fail to draw the necessary conclusions! Sadly, we have to look to doctors for the problems.

For decades, we have relied on the three symptoms of coughing, sputum production, and shortness of breath for the earliest possible diagnosis of COPD and believe that we can verify the diagnosis through lung function testing and spreading this misconception stereotypically in the guidelines.

We seem stubbornly resistant to acknowledging the fact that these symptoms only confirm that COPD has already become irreversibly established. Even lung function tests confirm obstruction at best, but not COPD, as there are also patients with COPD who have not "yet" developed obstruction. And smoking is also stereotypically treated as a risk factor.

How can early diagnosis and prognosis or quality of life for patients be optimized?

At the moment we neglect early diagnosis and waste the effects of existing treatment options. The number of patients with COPD "could" be reduced and the prognosis improved.

How can diagnosis and treatment be improved?

The future of early diagnosis will not be enabled by new examination methods such as high-resolution CT scans and the like. What is needed are diagnostic tools that are simple and cheap and over all accessible anywhere in the world.

We need to:

- Identify ***risk factors*** that increase the likelihood of developing COPD. Asking about smoking is no longer helpful, as we know that non-smokers are also increasingly developing COPD. There must therefore be other significant risk factors. There are certainly early indications [1], but unfortunately these are not given the appropriate importance and are not being scientifically investigated.

This search for early indications can only be carried out in frontline practices, by family physicians, not by pulmonologists, because by the time the patient "finally" ends up at the pulmonologist, the COPD is already established and usually more progressed. Only Family Physicians see patients for a variety of reasons and can register early warning signs of COPD, suspect the disease at an early stage, and influence its course with appropriate options, perhaps even preventing its onset.

- Search for ***therapeutic options*** to intervene in the process before COPD starts in order to prevent its development. This could include options that have already proven effective in the treatment of COPD, such as eliminating potential toxins, preventing respiratory infections, and physical activity. The search for further options has to go on.
- Search for ***signs that signal the onset*** of COPD in order to be able to intervene with appropriate options, perhaps even preventing its onset.

Once the disease has finally been diagnosed, but as usual late, usually discovered with the first exacerbation, therapy appropriate to the severity starts. And it is precisely at this point that the course of the disease and quality of life could almost certainly be improved.

The author's experience after almost 50 years of intensive work with asthma and COPD shows that it is often the little things that weigh heavily and prevent maximum effectiveness of therapy:

- The available therapeutic options are not consistently implemented. Therapy is often limited to vaccinations and medication.
- Information about the disease, the need for regular therapy, the necessity of regular therapy and therapeutic agents is insufficient or completely lacking.

If structured patient education is not possible, at least a short/individual training session tailored to the patient's needs must be provided [2-4]. This omission inevitably has a negative effect on adherence. We know that under these circumstances, patients tailor their therapy as they see fit, based more on subjective impressions than on necessity. For example, asthmatics prefer their reliever, whose effect they feel immediately, and refrain from inhaling their controller (ICS) because it does not provide an immediate effect. Therapy with a controller and reliever in one device is an enormous advance in this regard. Patients with COPD reduce necessary long-term regular therapy to on-demand therapy because they feel little effect.

The Torch study impressively demonstrated the great importance of good adherence. With comparable therapy, regular use significantly reduced mortality [5].

- Teaching the correct inhalation technique, including imitation, provided that a demo device with a disposable mouthpiece is available.
- Regular review of therapy and especially monitoring of inhalation technique.

All too often, inhalation technique is neither taught nor, worse still, checked. Studies on inhalation errors have shown no significant change in recent decades. Between 30 and 80% of all patients still make crucial mistakes. The sad result is that if inhalation is not performed correctly, nothing can reach the airways. This means that inhaled medications remain ineffective and only cost time and money.

Unfortunately, out of the experience of the author these shortcomings apply to both general practitioners and specialists. Even if there are only isolated examples of these shortcomings in specialist practices, the ratio of general practitioners to specialists—66,100 general practitioners to 1,200 pulmonologists in Germany—underlines the significance of this flaw in specialist practice, i.e. meaning that if one specialist is working insufficient it is comparable to 55 family physicians working insufficient.

Conclusion

The number of people at risk of COPD could be lower, and the quality of life and prognosis of patients with COPD could be improved in a simple way.

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