CORRESPONDENCE

GOLD COPD classification and prognostic pessimism regarding ICU admission

Incorporation of the Global Initiative for Chronic Obstructive Lung Disease (GOLD) classification of severity of expiratory airflow limitation in chronic obstructive pulmonary disease (COPD) into the recent National Institute for Health and Clinical Excellence (NICE) guidelines is welcome and sensible. Describing a forced expiratory volume in one second (FEV₁) of 51% predicted as ‘mild disease’ fails to capture the loss of lung function and irreversible damage done. Recognition and optimal early management of COPD cannot be overemphasised to limit its long-term health consequences.

However, we have concerns that its adoption without adequate explanation in the UK could have unintended negative consequences in this patient group if presenting acutely unwell, when decisions regarding intensive care and use of invasive mechanical ventilation (IMV) are being made.

Widely varying ICU admission criteria and prognostic pessimism among UK critical care physicians regarding COPD have been demonstrated. The description of a condition as ‘severe’, which could include those with an FEV₁ of up to 50% predicted and is not a comment on general functional capacity or physical frailty, may be misinterpreted by clinicians. This could then contribute to an overly nihilistic view of potential outcome and hence inappropriate refusal of intensive care for some who could benefit.

The recent National Chronic Obstructive Pulmonary Disease Resources and Outcomes Project report concerning acidosis and use of non-invasive ventilation (NIV) in COPD highlights several important issues regarding acute care. The use of IMV was low, 110 out of 2143 acidic patients received IMV and only 34 out of 1077 patients receiving NIV had treatment escalated to IMV. Given the methodology of this survey, it must be considered representative of UK practice.

First, we would suggest that in addition to explaining the recategorisation and its meaning to patients as O’Reilly and Rudolf suggest, this change needs to be shared with colleagues responsible for acutely ill COPD patients. Second, care should be taken with clinical letters and discharge documentation. Many hospitals have now adopted electronic patient record systems enabling clinical letters to be viewed without the paper notes being present. We would suggest that in addition to the GOLD classification, functional exercise capacity is recorded besides the absolute and predicted values of FEV₁ and forced vital capacity.

By being aware of potential problems, we can hopefully gain the benefits of bringing our practice in line with international colleagues without disadvantaging a vulnerable group.

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