

making optimal treatment decisions. But this aircraft cockpit metaphor reminded us that current evidence-based guidelines resemble the flight simulator rather than the real plane. In our everyday practice we base our decisions on the ‘dummy’ evidence derived from purified non-representative cohorts of COPD patients.² Examples are Body mass index, airflow Obstruction, Dyspnea, and Exercise capacity (BODE) index and COPD Assessment Test (CAT) that were developed in the studies without significantly comorbid patients. As well as the majority of inhaled treatments that were never specifically evaluated in multimorbid patients. But it is absolutely obvious that in real-life COPD patients, comorbidities are definitely the second prevalent sign after non-reversible obstruction.³ And it is well known (but imprudently neglected) that in COPD comorbidities significantly influence everything—from symptoms to mortality.⁴ So we suppose comorbidities deserve much greater attention. Since ‘COPD control panel’ aims to represent a possible new framework for future guidelines, we think it has to prioritise the place of comorbidities in the assessment of COPD patients. This will reinforce real holistic patient-centredness, balancing the risks of promoting disease-centred management due to modern deepening in ‘-omics’.

Another issue with current guidelines (and potentially with ‘control panel’ idea) is an inadequate implementation in practice. Information-overloaded and time-restricted primary care physicians usually are not prone to use sophisticated rules and tools. They would rather prefer a ‘one size fits all’ approach or at least using something they are very familiar with. That is why we think some reframing of the proposed ‘COPD control panel’ to two conventional domains—severity and control—would be useful for better patient-centredness, and provider recognition and implementation (figure 1).

Metaphorically, the ‘severity’ domain should tell us which parts of the aircraft are damaged and to what extent. So the severity of COPD should be described by the loss of functional reserve of all relevant target organs besides the lungs.⁵ Next, the ‘control’ domain should tell us if we have appropriate altitude, speed and direction to reach the destination point, so it must cover ‘impact’, ‘activity’ and compliance measures, restricted by those we really can control.⁶

We emphasise the value of the proposed ‘COPD control panel’ and suggest a slight modification to make it more personalised and decision-supportive as well as

The place of comorbidities in ‘COPD control panel’

We read with interest about the new chronic obstructive pulmonary disease (COPD) care framework proposed by Agustí and MacNee.¹ The ‘control panel’ idea is very interesting and useful because it allows keeping in mind all we need for

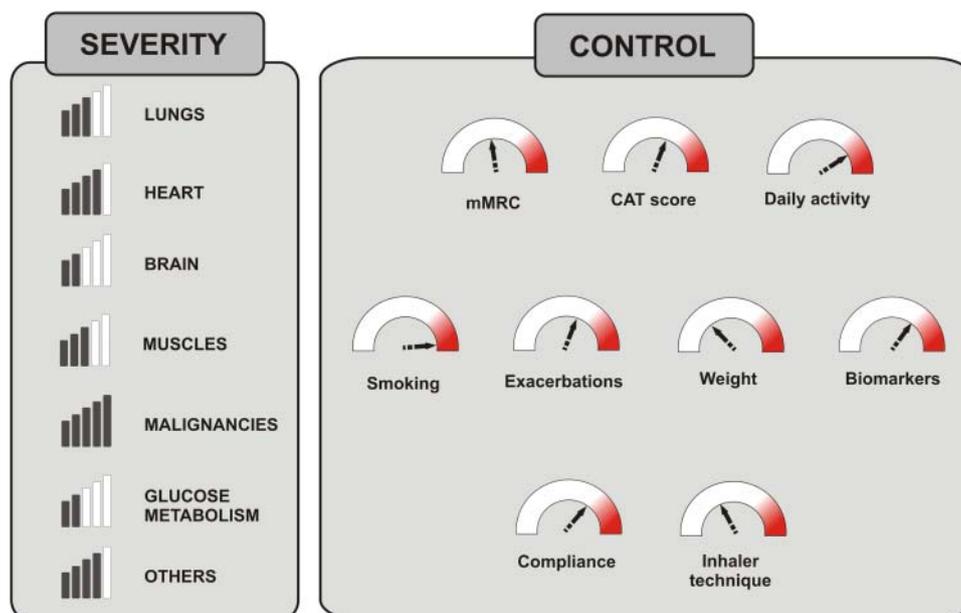


Figure 1 Modification of 'COPD control panel': emphasis on comorbidities and practical applicability. This figure is only reproduced in colour in the online version.

to facilitate implementation by primary care physicians.

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