Results We report the characteristics of the first 250 COPD patients from our ongoing 500 patient survey.

Basic demographics 55% Male, 45% Female. Mean age patients 68 ± 12 yrs, all patients were previous smokers with 56 ± 10 pkt/yrs smoking history. 34% remain current smokers.

Mean FEV1 48% ± 10%, Mean FEV1/FVC ratio 49% ± 10. Median mMRC dyspnea score 2. Mean CAT score 18 ± 10 (Range 0–38).

GOLD Stage Classification 13% GOLD Stage A, 67% GOLD Stage B, 1% GOLD Stage C and 19% GOLD Stage D. Current treatment LAMA (long-acting muscarinic antagonist) was prescribed to over 90% of all patients in groups B, C and D whereas monotherapy with LABA (long acting beta-agonist) or dual bronchodilator with LABA/LAMA therapy was prescribed to less than 5%.

There was significant overtreatment with ICS/LABA in all categories with high dose ICS (inhaled corticosteroid) being preferred. 20% of patients in GOLD Stage A where receiving Triple therapy (LAMA + ICS/LABA) and a further 20% where receiving monotherapy with ICS/LABA, yet had no history of exacerbations.

30% of patients in GOLD Stage B where receiving Triple therapy (LAMA + ICS/LABA) yet had no history of exacerbations.

Conclusion Current Canadian Guidelines and the GOLD strategy focus on symptom relief and striving to prevent exacerbations with step-wise prescription of short and long-acting bronchodilators with individual or combinations of LAMA, LABA, LAMA/LABA or ICS/LABA inhalers. Patients in GOLD Group C are rare. Current prescription choices in our survey does not reflect current evidence or guidelines. We report a heavy reliance on ICS/LABA along with over prescription of triple therapy at all stages of disease.

Results A total of two articles met the end criteria. Outcome shows improvement in exercise time (treadmill test) at 95% CI, with statistically significant benefit with mean difference of 335.18 [253.93, 416.43] favouring Pravastatin group. The studies show inconclusive results for Pravastatin in improving FEV1 (%) with 95% CI with mean difference of 0.05 [-0.61, 4.7]. The outcome in total lung capacity shows inconclusive results but shows a trend toward benefit with 95% CI with mean difference of -0.08 [-0.46, 0.30]. Inspiratory capacity results at 95% CI with mean difference of 0.13 [-0.06, 0.32] showed an inconclusive outcome but has a trend toward benefit. Improvement in the Borg dyspnea score at 95% CI, showing statistically significant benefit with mean difference of -2.91 [-3.19, -2.63] favouring the Pravastatin group.

Conclusions Statins already have an established role in treating cardiovascular patients because of their cholesterol-lowering ability, but also have anti-inflammatory and immunomodulatory effects that are beneficial in airway inflammation in COPD. Statin administration to COPD patients showed amelioration in exercise tolerance, improvement in dyspnea scores and augmentation in pulmonary function indices. Thus, statins may be useful as adjuvant to currently available therapies as well as improvement in lipid status.

Background Chronic obstructive pulmonary disease (COPD) is an inflammatory lung disease characterised by progressive airflow limitation. Statins have anti-inflammatory and immunomodulating properties that could alter inflammation of the airways. The objective of this study is to systematically evaluate the effectiveness of adjunct statin therapy in improving exercise tolerance and pulmonary function indices in patients with chronic obstructive pulmonary disease.

Introduction Tiotropium (T), a once-daily long-acting muscarinic antagonist, is a well-established first-line maintenance treatment in chronic obstructive pulmonary disease (COPD); olodaterol (O) is a once-daily long-acting β2-agonist that has recently gained approval in several countries. Two Phase III replicate pivotal studies assessed the efficacy and safety of fixed-dose combinations of T and O (T+O) delivered via Respimat™ Soft Mist™ inhaler in patients with GOLD 2-4 COPD.

Methods Two 52-week, double-blind, parallel-group studies randomised 5162 patients to O 5 μg, T 2.5 μg, T 5 μg, T+O 2.5/5 μg or T+O 5/5 μg. Primary efficacy end points were trough forced expiratory volume in 1 second (FEV1) response (ie change from baseline), FEV1 area under the curve from 0–3 h and St George’s Respiratory Questionnaire (SGRQ) total score after 24 weeks. Pooled data from the two studies are presented here; lung function from the individual studies will subsequently be provided.

Results All treatments resulted in clinically relevant improvements in lung function, with significant increases with both T +O doses over the individual components (p1 responses were 0.055 L (O 5 μg), 0.073 L (T 2.5 μg), 0.080 L (T 5 μg), 0.118 L (T+O 2.5/5 μg), 0.137 L (T+O 5/5 μg) and mean differences of 0.07 ± 0.07). Improvement in SGRQ total score was 4.1 ± 4.2 units in T+O 2.5/5 μg group and 3.3 ± 4.2 units in T+O 5/5 μg group. Safety of all treatment groups was consistent with the approved product profile.