LETTER

Implementing the change in National Institute for Health and Clinical Excellence guidance on airflow obstruction grading in chronic obstructive pulmonary disease

The updated National Institute for Health and Clinical Excellence (NICE) chronic obstructive pulmonary disease (COPD) guidelines1 and the draft national strategy for COPD2 have recommended a change in the classification of airflow obstruction severity to align them with international classifications. NICE’s 2004 guidelines recognised that disease severity is not the same as the severity of airflow obstruction and has recommended using other measures such as the Medical Research Council (MRC) dyspnoea scale, exacerbation frequency and multicomponent indices.3 However, UK primary care has been encouraged to code disease severity into primary care records without any conflicting advice. Perhaps the answer is to abolish the codes for mild moderate and severe COPD and for new codes for airflow obstruction based on GOLD stages 1–4 to be generated. For practical purposes of classifying COPD severity, for example, for deciding the frequency of reviews, the MRC dyspnoea scale could replace H36–8 as markers of disease severity. The MRC scale is already being recorded in primary care. In future, COPD severity codes should be based on multicomponent indices, at present a suitable index for primary care has not been chosen. The NICE guidelines recommend the use of the BODE index when its component items are available, the need for the six minute walking test will make this impractical for routine use in primary care and there is insufficient evidence to approve newer indices such as the ADO4 and DOSE.5

Action is required now to address both the coding and communication issues so that the sensible advice from NICE can be implemented without causing confusion in primary care and distress to patients.

Rupert C M Jones,1 Kevin Gruffydd-Jones,2 David B Price3

REFERENCES