

COPD or functionally COPD?

Duarte-de-Araújo A^{1,2,3*}, Hespanhol V^{4,5} and Correia-de-Sousa J^{1,2,6}

¹Life and Health Sciences Research Institute (ICVS), School of Medicine, University of Minho, Braga, Portugal

²ICVS/3B's, PT Government Associate Laboratory, Braga/Guimarães, Portugal

³Respiratory Department, H. S^a Oliveira, Guimarães, Portugal

⁴Department of Pneumology, Centro Hospitalar de S. João, Porto, Portugal

⁵Faculty of Medicine (FMUP), University of Porto, Portugal

⁶Horizonte Family Health Unit, Matosinhos, Portugal

The recent paradigm shift in the treatment of COPD has led many physicians to withdraw inhaled corticosteroids to a significant group of patients with obstructive airways disease with no recent history of exacerbations. Many of these patients, until then symptomatically stabilized, became more acute, and this persistence in ICs withdrawing seems to be justified by complying with international guidelines. The basis of this problem seems to lie in the chronic confusion between COPD and non-reversible or only partially reversible obstruction of the airways, that is, a functionally COPD. Moreover, safe withdrawal or deprescribing of ICS in patients with COPD should be done according to sound criteria [1].

In medical discourse, the name of a disease refers to a set of abnormal phenomena, exhibited by a group of individuals in such a way as to place them at a biological disadvantage [2]. The diagnostic process is the objective assessment of this biological disadvantage, the conclusion of which is the name of the disease. Disease is thus an intellectual elaboration, since it does not exist separately from the subject who suffers from it. Its main function is to facilitate the communication within the medical and scientific community.

The definition of any disease may be based on aetiology, on a clinical description, on a structural abnormality, or on a disorder of function. According to GOLD, updated in 2018, COPD is a common, preventable and treatable disease that is characterized by persistent respiratory symptoms and airflow limitation that is due to airway and/or alveolar abnormalities, usually caused by significant exposure to noxious particles or gases [3]. This consensus definition contains all the defining elements of a disease. However, the significant overlap between the clinical, functional, and structural characteristics of patients with asthma diagnosis, leads to difficulty in differential diagnosis.

A persistent obstruction of the airways is essential for the diagnosis of COPD and is also the easiest feature to document in clinical practice. However, it is not pathognomonic of COPD. In asthma patients, the airway inflammation and airflow limitation may lead to lung remodelling, resulting in irreversible airflow obstruction [4]. Because of that, some authors refer a significant association between active asthma and the subsequent development of COPD [5]. More recently, this association or progression is called Asthma COPD Overlap (ACO). Patients with fixed airflow limitation show distinct pathologic and functional characteristics, depending on a history of either COPD or asthma [6]. They also have a different response to steroids and a different prognosis. In fact, different airways diseases may exhibit a

chronic airflow limitation, and chronic obstructive lung disease, as defined, is more than a disorder of function.

A definition of a disease is an important matter in medicine, but the role of medicine is mainly to help patients. Patients with airway disease seek medical attention not because of asthma, COPD or airflow limitation. Some patients have respiratory symptoms with significant variability, although they have periods in which they feel completely well. Some other patients seek medical attention because, although their symptomatology is stable, their dyspnoea is such that it severely impairs their quality of life. Many patients, however referring variation or instability of symptoms beyond physical exertion, are always more or less symptomatic. In any group of individuals with airway disease we should question about the severity of the disease and its impact on well-being; the activity level of the disease; the treatable traits in as particular patient or group of patients [7]; and which should be treated or prevented. Patient health status is what matters in medicine, and the added value are the interventions in order to improve patient's health status. Guide-lines are important tools, based in the best medical evidence, but should be questioned, as should the current diagnosis. After all, we currently have only three major groups of drugs to treat COPD patients: muscarinic antagonist bronchodilators, β -agonist bronchodilators, and inhaled corticosteroids. And these three groups are the same ones we use to treat asthma.

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Correspondence to: Duarte-de-Araújo A, Life and Health Sciences Research Institute (ICVS), School of Medicine, University of Minho, Braga, Portugal; Tel: +351 965542786; E-mail: duartearaujo@apo.pt

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