A united approach to COPD management

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A shift in doctor and nurse attitudes has been the single most important change in COPD care in general practice over the last 10 years. There seemed to be nothing to do for these people and no reason to do anything. Large numbers of inhalers were dispensed without much monitoring of use and patients were dispatched to hospital for the inevitable exacerbations. If this sounds anything like your current practice, the CME papers in this issue may encourage change in your COPD patients' management.

A number of primary care organisations have initiated programmes aimed at improving care for people with COPD. Why have they chosen a chronic disease with so little attached glamour? Any programme is likely to be more successful at changing practice if there is gap between usual care at the start and best practice. This has been shown to be the case with inaccurate diagnosis, under-diagnosis and over and under treatment being common. Funders want good management of COPD because it is a costly disease in New Zealand with frequent, lengthy hospital admissions.

Flu vaccination and pneumococcal immunisation are important for COPD patients

The list of evidence-based interventions that are of benefit is quite lengthy, but most are within the means of an enthusiastic practice team such as use of spirometry for diagnosis and flu vaccination to help prevent exacerbations. Patients are very grateful for the attention of a new approach by their practice. They have often picked up the negative perceptions of their disease and respond well to small efforts made on their behalf. Spirometers are essential to the proper diagnosis of COPD and opportunistic testing of smokers aged over 50 produces surprising results. A high index of suspicion is needed when smokers get chest infections in the winter. Systematic recall of smokers over age 50 is still beyond many practices that do not routinely record smoking status. Diagnosis should follow GOLD criteria and alternate diagnoses need to be considered.

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Once abnormal spirometry is found, automatic prescription of high dose inhaled corticosteroids and combined bronchodilators is tempting but should be resisted. All patients admitted with an exacerbation of chronic airways disease are discharged on these medications even if a steroid responsiveness trial and bronchodilator trial have shown no benefit. Primary and secondary care need to work together to address this issue, which drives cost as well as being poor care. A better approach is to refer your newly-diagnosed patient for full spirometry including a repeat test after a trial of inhaled or oral steroids using a standard protocol.

Once accurately diagnosed, smoking cessation, lifestyle and medication education can begin. This is where a team approach with practice nurses and local support groups can be very effective. Doctors frequently assist with smoking cessation, sometimes check inhaler technique but rarely tackle areas such as management of breathless episodes, anxiety attacks, weight loss and exercise classes. Packs of resources for nurses and local education sessions allow these issues to be tackled in fairly brief sessions over time.

Flu vaccination and pneumococcal immunisation are important for COPD patients. The Ministry of Health is beginning to consider the merits of the latter but many patients will pay for the vaccine when offered, especially if they are allowed to save up for it or if flexible payment terms are offered. Most New Zealand patients are not offered the vaccine because doctors perceive that cost is a barrier or are unaware of the evidence for benefit.

Exacerbations of COPD not only have significant morbidity and mortality but are very disruptive to the lives of patients and their families.

The anxiety and stress is enormous and may be reduced by a pro-active approach. General practice teams can rehearse with a patient and his or her family the steps required to increase medication, when, where and how to seek help and self-help techniques such as breathing exercises. The efficacy of this approach is being tested in a randomised, controlled trial in Christchurch of self-management plans and home prescription of antibiotics and prednisone.

The palliative care of end-stage chronic airways disease can be very challenging and often requires intensive input from a multi-disciplinary team involving primary and secondary care. Christchurch is fortunate to have an excellent Outreach service which helps to look after this group of patients. The challenge is to keep the general practice team involved in a model of service delivery that is based in the hospital.

What are the opportunity costs of this intensive input to a few patients? Is it practical in our current environment and what about all the other chronic diseases clamouring for attention? The Diabetes *Get-Checked* programme has introduced New Zealand general practice to regular review with some positive results. Local experience in Christchurch is that many practices have found the systematic approach easy to adopt but others have struggled. Many of the services required are common to all chronic diseases (prevention, accurate diagnosis, regular review, patient education, self-management). The challenge for general practice is to develop tools for all chronic diseases with specific strategies for focussing on each disease. A different way of working for each disease is impractical. We can remain generalists by adapting the disease management approach in this way.

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In summary, COPD is a condition that offers practice teams the opportunity to manage a rewarding group of patients very well. Teams can achieve the systematic approach required for the relatively small group of patients with COPD in a practice. They may then be better equipped to use the skills developed for other chronic diseases with more daunting numbers.