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We must join forces in the battle against COPD

To the Editor:

The recently published American Thoracic Society (ATS)/European Respiratory Society (ERS) statement on research questions in chronic obstructive pulmonary disease (COPD) [1] is an excellent and extensive document. It will, without doubt, contribute to better understanding of COPD and hopefully direct research to important unmet needs. Our only disappointment is that the authors did not include significant representation from primary care or public health: disappointing because globally most people with COPD are diagnosed and managed in the community by primary care clinicians, and many of the unmet individual and population research needs can only be defined and answered by professionals working in these settings.

5 years ago, the International Primary Care Respiratory Group (IPCRG) published a research needs statement written by practising primary care clinicians from 22 countries with a range of socioeconomic backgrounds [2]. We identified 145 research questions to set the agenda for primary care research in the context of diagnosis and management of asthma, allergic rhinitis, COPD, tobacco dependence and respiratory infections. This was followed in 2012 by a Delphi exercise in which 22 global participants prioritised the questions based on their clinical importance, feasibility and international relevance. This generated a list of seven research questions that achieved total agreement and 24 that reached the consensus threshold of 90% [3]. The themes we identified 3 years ago remain relevant today. Many are echoed in the ATS/ERS statement: how a prompt diagnosis of a respiratory disease can be suspected in a consultation and the condition assessed; and effective approaches to implementing self-management, adjusting treatment regimens and encouraging treatment adherence. We too highlighted that multimorbidity is the norm in people with COPD [4], and called for research to define the approach to care for a multimorbid patient who may have a range of physical and mental health problems (specifically including tobacco dependency), and who is at risk from polypharmacy [5].

However, the IPCRG Delphi process also prioritised other, very basic questions: what are the "simple" tools and pragmatic approaches for diagnosing and assessing patients in the low-tech community environment; how can guidelines be implemented; and how do we educate and support clinicians to tackle chronic respiratory diseases? These questions are absent from this ERS/ATS statement and yet without addressing these implementation science questions, there will be no significant improvement in COPD diagnosis and care.

In addition, any statement of research needs for COPD needs to be set in the context of the noncommunicable disease epidemic, and reflect that most new cases will be in low- and middle-income countries. The World Health Organization estimates that 2.4 billion people, generally among the world's poorest, rely on biomass fuels for their heating and cooking [6]. The IPCRG has highlighted in its FRESH AIR work the significance of biomass fuels as a cause of COPD, often in relatively young populations: 40% of the people with COPD in our Ugandan project were <40 years of age [7]. This is a priority for our international group with a reach of 125 000 primary care clinicians worldwide. The only way to address such challenges is a population health approach to reduce smoking and exposure to biomass smoke. Furthermore, the global economic cost of COPD is US$2.1 trillion [8]. Governments and their healthcare systems need research to enable them to understand the most cost-effective interventions for populations, and how to achieve the greatest value from drug and nondrug healthcare interventions.

The IPCRG called for research "undertaken within primary care, recruiting participants representative of primary care populations, evaluating interventions realistically delivered over appropriate timescales within primary care, and drawing conclusions that will be meaningful to professionals working within primary care" [3]. Bridging the second translational gap, such research will generate evidence relevant to the care of people with COPD in their communities.

The pity is that neither we, nor the authors of the ATS/ERS statement, thought to work together in defining research needs. Both the ATS/ERS and IPCRG documents are important, as we all are committed to the common goal of reducing patients' burden from respiratory diseases. The separation of primary and secondary care is likely to be a barrier to reaching this goal in the long term. To quote HOLGATE [9] in an editorial that accompanied the IPCRG research priorities: "What is now needed is to turn these priorities into research questions and grant proposals and, of course, for funding to follow. The only way this will occur is for the respiratory research community to join forces with this in mind and to move the exciting challenge provided by this game-changing exercise into high quality research proposals, capacity building, new evidence and subsequent benefit to patients. We now all need to take individual and joint responsibility for this grand challenge."

It is time to join our forces if the battle against COPD is to be won.

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Specialists and primary care physicians must join forces in the battle against COPD!
http://ow.ly/Q8A3L

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From the authors:

We applaud and totally agree with the concept expressed by A. Ostrem and colleagues that in order to win the battle against chronic obstructive pulmonary disease (COPD) we must all join forces. Indeed, the coincidence of important research questions related to COPD between the document generated by the International Primary Care Respiratory Group (IPCRG) in 2010 [1] and the recently published American Thoracic Society (ATS)/European Respiratory Society (ERS) statement on research questions in COPD [2] is evidence of the agreement that exists among everyone interested in this topic.

However, it is not totally true that the ATS/ERS document left out important questions that were raised in the IPCRG document. These questions included the use of "simple" tools and "pragmatic" approaches for diagnosing and assessing patients in low-tech communities. The ATS/ERS document addressed the issue of diagnosis and recommended the following. Studies should be undertaken to measure the accuracy of various tools (*e.g.* questionnaires) to detect symptoms in patients at risk for COPD, using spirometry as the reference standard. Studies should be carried out to compare outcomes among symptomatic individuals whose COPD diagnosis is based on the combination of airflow limitation confirmed by spirometry and a history of exposure to the causative agent with outcomes among symptomatic individuals whose COPD diagnosis has not been confirmed with spirometry, but rather is based on an alternative approach. Examples of alternative approaches include various combinations of symptoms, imaging findings, and physiological abnormalities measured by complementary tests such as forced oscillation techniques, and studies that evaluate case-finding strategies using questionnaires, mini-spirometers and office spirometry in areas where access to conventional spirometry requires specialised assessment. Addressing the question of using "simple" tools in the diagnosis of COPD is implicit in these recommendations for research. In relation to the questions of how to implement guidelines and how to educate clinicians to tackle respiratory diseases, the ATS/ERS statement was neither a guideline, nor was it developed to teach clinicians how to tackle "respiratory diseases". The last two questions are very worthwhile goals that were not addressed by either the ATS/ERS statement [2] or the IPCRG document [1], and require a much wider audience to develop the appropriate framework for their research.

We also believe that it is a pity that neither we, nor the IPCRG thought to work together on these documents, but optimistically look at the convergence of thoughts and action as a positive step to help decrease the burden that COPD places on humanity. Let us continue joining forces.

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ATS/ERS task force agrees coordinated action by all groups (including patients) aimed at combating COPD is beneficial http://ow.ly/R2oNy

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