

1: COPD | American Journal of Managed Care

30,31 GOLD guidelines suggest that patients with comorbid COPD and lung cancer should receive the same treatment for each condition as would be recommended for patients with either diagnosis alone 32; however these recommendations are often limited by the severity of underlying respiratory disease including surgical, chemotherapeutic and.

Chronic Obstr Pulm Dis. ACOS represents a clinical diagnosis and should be considered among patients with persistent airflow limitation and a combination of features typically associated with both asthma and COPD. Despite these characteristics, classic COPD features may still be present, such as hyperinflation or computerized tomography CT -defined emphysema. Identification of patients with ACOS is critical because outcomes for patients with ACOS may be worse than those for patients with COPD or asthma alone; 7 as a result, subspecialty referral is often required to ensure appropriate diagnosis and treatment. Therefore, distinguishing ACOS from singular COPD may be more appropriately performed by utilizing biological features that may reflect the underlying disease pathology and the response to therapy. A subset of patients with COPD are known to exhibit eosinophilic, rather than neutrophilic, inflammation. Sputum eosinophilia has been found to correlate with responsiveness to both systemic 11,12 and inhaled 13,14 corticosteroids among COPD patients. Additional targeted therapy beyond corticosteroids has been suggested for eosinophilic COPD patients with the medication benralizumab, a monoclonal antibody that inhibits interleukin As opposed to traditional clinically-driven phenotypes, ACOS may be better defined by biological tools, such as blood or sputum eosinophil count. Use of these biologic markers may more accurately characterize the underlying pathophysiology and predict targeted therapeutic responsiveness. COPD and Lung Cancer Lung cancer is the leading cancer cause of death among both men and women in the United States 16 and kills more people annually than colorectal, breast, prostate and pancreatic cancers combined. Approximately 42 million American adults currently smoke cigarettes, 18 million have COPD, 1,19 and approximately , have lung cancer. LVRS showed the greatest benefit for patients with upper lobe predominant emphysema and poor exercise capacity following pulmonary rehabilitation 37 ; therefore these COPD patients who have resectable lung cancer in an upper lobe may derive dual benefit from surgery. Given the known poor prognosis for lung cancer among COPD patients and the many limitations to providing standard therapies for these patients, prevention and screening are critical components of care. Aggressive tobacco cessation efforts 38 and targeted screening chest CT scans 39 are imperative in the care of COPD patients. As the performance of chest CTs increases for the purposes of lung cancer screening, bronchiectasis will likely become increasingly recognized. Despite this clinical overlap, recognition of bronchiectasis among patients with COPD is important because its presence is associated with worse outcomes. Specifically, outpatients with comorbid bronchiectasis and COPD suffer more frequent respiratory exacerbations, higher rates of potentially pathogenic microorganisms isolated in their sputum, and increased mortality. In non-cystic fibrosis-related bronchiectasis, colonization with *Pseudomonas aeruginosa* has been associated both with disease progression, defined by forced expiratory volume in 1 second decline, 48 and mortality. In summary, bronchiectasis is prevalent among patients with advanced COPD and may represent a distinct phenotype that warrants targeted therapy. COPD and Interstitial Lung Disease Emphysema and fibrosis are radiographically and physiologically defined features that individually represent the extremes of lung disease but can coexist. Emphysema is characterized by a loss of lung tissue, decreased lung recoil and airflow obstruction; whereas fibrosis is characterized by a gain of lung tissue, increased lung recoil and airflow restriction. The overlap of these 2 conditions, likely related to the common exposure of tobacco smoke or other noxious particles or gasses, results in pseudo-normalization of spirometry and lung volumes and an isolated, severely reduced diffusion capacity. CPFE was first recognized in but the prevalence of these overlapping diseases has become increasingly apparent as the performance of HRCTs increases. Presently, research is focused upon identifying radiographic precursors of CPFE to identify

those at risk for disease earlier, at which time interventions may afford greater benefit. The Muc5B promoter polymorphism, highly associated with idiopathic pulmonary fibrosis, is now recognized to be associated with interstitial lung disease in the general population. Radiographic and genetic methods are being developed to identify patients at risk for this manifestation of COPD. These tools will additionally allow the identification of optimal subpopulations for clinical therapeutic trials. Conclusions In conclusion, COPD is a prevalent and morbid condition, complicated by comorbid diseases and overlapping pulmonary syndromes. Better characterization of these overlapping syndromes may afford enhanced diagnostic methods, prognostication, and ultimately therapeutic intervention and outcomes. Declaration of Interest Dr. Woodruff has served as an advisor for Janssen, Neostem and Genentech. He has been a consultant for Roche, Novartis and AstraZeneca and has received a grant from Genentech. Washko has served as a consultant for GlaxoSmithKline and his spouse is employed by Merck. Centers for Disease Control and Prevention. Chronic Obstructive Pulmonary Disease. Centers for Disease Control and Prevention website. Accessed December 20, Systemic manifestations and comorbidities of COPD. Complex chronic comorbidities of COPD. Chronic obstructive pulmonary disease phenotypes: Identification of five chronic obstructive pulmonary disease subgroups with different prognoses in the ECLIPSE cohort using cluster analysis. *Annals Am Thoracic Soc*. Global Initiative for Asthma. Diagnosis of Diseases of Chronic Airflow Limitation: Global initiative for chronic Lung Disease website. A Systematic Review and Meta Analysis. Inflammometry to assess airway diseases. Saha S, Brightling CE. Eosinophilic airway inflammation in COPD. Eosinophilic inflammation in COPD: Prevalence and clinical characteristics. Sputum eosinophilia and short-term response to prednisolone in chronic obstructive pulmonary disease: Eosinophilic airway inflammation and exacerbations of COPD: Sputum eosinophilia and the short term response to inhaled mometasone in chronic obstructive pulmonary disease. Benralizumab for chronic obstructive pulmonary disease and sputum eosinophilia: Lung Cancer Fact Sheet: Estimated Cancer Deaths by Site, American Lung Association website. Smoking and Tobacco Use: National Institutes of Health. Updated March 29, Lung and Bronchus Cancer. National Cancer Institute website. COPD prevalence is increased in lung cancer, independent of age, sex and smoking history. Prevalence of COPD in women compared to men around the time of diagnosis of primary lung cancer. Congleton J, Muers MF. The incidence of airflow obstruction in bronchial carcinoma, its relation to breathlessness, and response to bronchodilator therapy. Airways obstruction and the risk for lung cancer. Higher risk of lung cancer in chronic obstructive pulmonary disease. A prospective, matched, controlled study. Lung cancer in patients with chronic obstructive pulmonary disease-- incidence and predicting factors. Chronic obstructive pulmonary disease and altered risk of lung cancer in a population-based case-control study. Effect of emphysema on lung cancer risk in smokers: Lung cancer in chronic obstructive pulmonary disease: Chronic obstructive pulmonary disease and subsequent overall and lung cancer mortality in low-income adults. Recent trends in lung cancer and its association with COPD: *Prim Care Respir J*. Functional evaluation of the lung resection candidate. Operative mortality and respiratory complications after lung resection for cancer: Surgery for non-small cell lung cancer. A randomized trial comparing lung-volume-reduction surgery with medical therapy for severe emphysema. *New Eng J Med*. Smoking cessation in chronic obstructive pulmonary disease. Reduced lung-cancer mortality with low-dose computed tomographic screening. Airflow limitation and histology shift in the National Lung Screening Trial. Factors associated with bronchiectasis in patients with COPD. Bronchiectasis, exacerbation indices, and inflammation in chronic obstructive pulmonary disease. Physiological and radiological characterisation of patients diagnosed with chronic obstructive pulmonary disease in primary care. Prognostic value of bronchiectasis in patients with moderate-to-severe chronic obstructive pulmonary disease. Does coexistence with bronchiectasis influence intensive care unit outcome in patients with chronic obstructive pulmonary disease? Factors associated with lung function decline in adult patients with stable non-cystic fibrosis bronchiectasis. British Thoracic Society guideline for non-CF bronchiectasis. Inhaled antibiotics for lower airway infections. Chronic obstructive pulmonary disease and bronchiectasis. *Curr Opin Pulm Med*. Combined pulmonary fibrosis and emphysema syndrome: Combined

pulmonary fibrosis and emphysema: Jankowich MD, Rounds S.

2: Publications Authored by Mark T Dransfield | PubFacts

diagnosis of bronchiectasis may also carry therapeutic relevance regarding the approach to microorganisms isolated in sputum, the role for bronchial hygiene, and.

3: - NLM Catalog Result

Contents: The worldwide epidemic of COPD: clinical phenotypes / Barry J. Make and James D. Crapo -- Diagnosis of COPD and the GOLD guidelines / Mark T. Dransfield -- Pathophysiology of COPD / Peter J. Barnes -- Clinical physiology of COPD / Matthew Hegewald, Robert Crapo, and Robert Jensen -- Genetics and racial, ethnic, and gender.

4: COPD9USA : COPD Overlap Syndromes | Journal of COPD Foundation

The GOLD guidelines suggest using the COPD Assessment Tool (CAT) or the modified Medical Research Council (mMRC) dyspnea scale, although the latter does not assess COPD-related symptoms other than breathlessness. The most widely used research tool, the St. George's Respiratory Questionnaire (SGRQ), is a 76 item questionnaire that includes.

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