

Principal Investigator &
Program Director
R. William Vandivier, MD

Co-Investigators
Norbert F. Voelkel, MD
Kelly E. Greene, MD
Thomas J Stelzner, MD
John M. Westfall, MD
Jeffery J. Glasheen, MD
Jim Grigsby, PhD
Sung-joon Min, PhD
Cynthia Hartsfield, PhD
Debra P. Ritzwoller, PhD, RRT

Program Coordinator
Patricia B. Koff, MEd, RRT

Participating Institutions
University of Colorado Hospital
Kaiser Permanente
University of Colorado at Denver and
Health Sciences Center

Contact Numbers at
University of Colorado
Patty Koff, MEd, RRT
Program Coordinator
(303) 476-8049

Fran Piedalue, RRT
Care Coordinator
(303) 476-8053

Tammie Freitag, RN
Care Coordinator
(303) 476-8052

Debbie Diaz
Administrative Assistant
(303) 372-8378

Contact Numbers at
Kaiser Permanente
Christine Kveton, RRT
Care Coordinator
(303) 476-8050

Stephanie Carwin, RRT
Care Coordinator
(303) 476-8055

Contact Number at
High Plains-Eastern CO.
Christin Sutter
(303) 921-8744

www.copdehealth.org

University of Colorado Hospital, COPD eHealth
4200 E. 9th Ave., Mail Stop C300, Denver, CO 80262
(303) 372-8378

**COPD is currently the FOURTH leading cause of death
in the world.**



REMEMBER!

Cold and flu season is almost here. Be sure to remind your patients to get their flu shot early and their pneumovax if they have not had one (before age 65 and again after age 65).

Table 5 - Key Indicators for Considering a Diagnosis of COPD
Consider COPD and perform spirometry if any of these indicators are present. These indicators are not diagnostic by themselves, but the presence of multiple key indicators increases the probability of a diagnosis of COPD. Spirometry is needed to establish a diagnosis of COPD.

Chronic cough: present intermittently or every day
often present throughout the day
seldom only nocturnal

Chronic sputum production: any pattern of chronic sputum
production may indicate COPD

Dyspnea that is: progressive (worsens over time)
persistent (present every day)
described by the patient as:
"increased effort to breathe,"
"heaviness," "air hunger," or "gasping"
worse on exercise
worse during respiratory infections

History of exposure to risk factors: tobacco smoke
occupational dusts and chemicals
smoke from home cooking especially:
and heating fuels

DIFFERENTIAL DIAGNOSIS OF COPD

Diagnosis	Suggestive Features
COPD	Onset in mid-life Symptoms slowly progressive Long smoking history Dyspnea during exertion Largely irreversible airflow limitation
Asthma	Onset early in life (often childhood) Symptoms vary from day to day Symptoms at night/early morning Allergy, rhinitis and/or eczema also present Family history of asthma Largely reversible airflow obstruction
Congestive Heart Failure	Fine basilar crackles on auscultation Chest X-ray shows dilated heart, pulmonary edema PFTs indicate volume restriction, not airflow limitation
Bronchiectasis	Large volumes of purulent sputum, commonly associated with bacterial infection Coarse crackles/clubbing on auscultation Chest X-ray/CT shows bronchial dilatation, bronchial wall thickening
Tuberculosis	Onset all ages Chest X-ray shows lung infiltrate or nodular lesions Microbiological confirmation High local prevalence of tuberculosis
Obliterative Bronchiolitis	Onset in younger age, nonsmokers May have history of rheumatoid arthritis or fume exposure CT on expiration shows hypodense areas
Diffuse Panbronchiolitis	Most patients male and nonsmokers Almost all with chronic sinusitis Chest X-ray and HRCT show diffuse small centrilobular nodular opacities and hyperinflation

MANAGEMENT OF COPD

Effective management of COPD includes four components:

1. Assess and monitor disease.
2. Reduce risk factors.
3. Manage stable COPD.
4. Manage exacerbations.

GOALS OF EFFECTIVE MANAGEMENT

These goals should be reached with a minimum of side effects from treatment:

1. Prevent disease progression.
2. Relieve symptoms.
3. Improve exercise tolerance.
4. Improve health status.
5. Prevent and treat complications.
6. Prevent and treat exacerbations.
7. Reduce mortality.

Coming in the next issue of GOLD Nuggets

- managing stable COPD
- appropriate medication strategies
- oxygen therapy

SMOKING CESSATION...HOW YOU CAN HELP

Smoking cessation is the single most effective way to reduce and stop progression of COPD.

Guidelines published by the U.S. Agency for Health Care Policy and Research in 1996 and updated in 2000 by the U.S. Public Health Service in *Treating Tobacco Use and Dependence: A Clinical Practice Guideline*, recommend a five-step approach:

- **Ask** every smoker at every visit about his or her tobacco use.
- **Advise** smokers to quit at every visit. Urge them in a clear, concise, strong manner to quit.
- **Ask** every smoker if he or she is willing to quit at this time.
- **Assist** smokers by helping them develop a plan:
 - Provide practical counseling.
 - Provide intra-treatment social support.
 - Help the patient obtain extra-treatment social support.
 - Recommend use of pharmacotherapy except in special circumstances.
 - Provide supplementary materials.
- **Arrange** follow-up contact in person or by phone.