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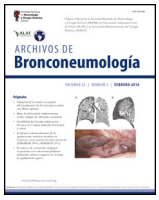

Special article

Consensus on the Asthma–COPD Overlap (ACO) Between the Spanish COPD Guidelines (GesEPOC) and the Spanish Guidelines on the Management of Asthma (GEMA)☆

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ABSTRACT

Following a proposal by the Spanish Society of Pulmonology and Thoracic Surgery (SEPAR), sponsor of the Spanish COPD Guidelines (GesEPOC) and the Spanish Guidelines on the Management of Asthma (GEMA), authors of both papers have unified the criteria for the diagnosis of asthma–COPD overlap (ACO).

This consensus defines ACO as the presence in a given patient of three elements: significant smoking exposure, chronic airflow limitation and asthma. Diagnosis is confirmed when a patient (35 years of age or older), smoker or ex-smoker of more than 10 pack-years, presents airflow limitation (post-bronchodilator $FEV_1/FVC < 0.7$) that persists after treatment with bronchodilators and inhaled corticosteroids (even after systemic corticosteroids in selected cases), and an objective current diagnosis of asthma (according to GEMA criteria). In cases in which the diagnosis of asthma cannot be demonstrated, marked positive results on a bronchodilator test ($FEV_1 \geq 15\%$ and ≥ 400 ml) or elevated blood eosinophil count (≥ 300 eosinophils/μL) will also be diagnostic of ACO.

The opinion of another 33 experts who had not participated in the consensus was sought using a modified Delphi survey. Up to 80% of respondents gave a very positive opinion of the consensus, and declared that it was better than other previous proposals. The GesEPOC-GEMA consensus on ACO provides a unique perspective of the diagnostic problem, using a simple proposal and a pragmatic diagnostic algorithm that can be applied at any healthcare level.

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Consenso sobre el solapamiento de asma y EPOC (ACO) entre la Guía española de la EPOC (GesEPOC) y la Guía Española para el Manejo del Asma (GEMA)

Palabras clave:
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R E S U M E N

A instancias de la Sociedad Española de Neumología y Cirugía Torácica (SEPAR), promotora de la Guía española de la EPOC (GesEPOC) y de la Guía Española para el Manejo del Asma (GEMA), autores de ambas guías han unificado criterios diagnósticos del solapamiento asma y EPOC (Asthma-COPD Overlap [ACO]). Este consenso define al ACO como la coexistencia en un mismo paciente de tres elementos: tabaquismo, limitación crónica al flujo aéreo y asma. La confirmación diagnóstica se establece cuando un paciente (≥35 años) fumador o exfumador (≥10 paquetes-año) presenta obstrucción o limitación crónica al flujo aéreo (FEV_1/FVC post-broncodilatador <70%), que persiste tras tratamiento broncodilatador y esteroideo inhalado (incluso oral en casos seleccionados) y diagnóstico objetivo de asma actual (según criterios GEMA). En los casos en los que este último no se pueda establecer, se aceptará una prueba broncodilatadora espirométrica muy positiva (FEV_1 ≥15% y ≥400 ml) o una elevada eosinofilia en sangre (≥300 eosinófilos/μl).

Se solicitó la opinión (mediante encuesta Delphi modificada) a otros 33 expertos que no habían participado en la elaboración del consenso. Un 80% de estos lo valoró positivamente, incluso superior a otras propuestas recientes. El consenso GesEPOC-GEMA sobre ACO proporciona una visión unitaria del problema, con una propuesta conceptual sencilla y un algoritmo diagnóstico pragmático, aplicable en cualquier nivel sanitario de nuestro ámbito.

Introduction

Asthma and chronic obstructive pulmonary disease (COPD) are different chronic respiratory diseases, but the prevalence of both is high, causing some patients to present both entities concomitantly. The Spanish COPD guidelines (GesEPOC)[1] were the first to recognize this phenotype,[2] calling it the mixed COPD–asthma phenotype, but since then it has received several names, the most widely recognized nowadays being asthma–COPD overlap, or simply the acronym ACO. From the time it was identified, the notion of overlap has generated considerable debate, and some issues, particularly surrounding concept and diagnosis, remain unclear. Despite the rapprochement of opinions between asthma and COPD experts,[3] no uniform criteria are available to define ACO in patients with a previous diagnosis of asthma or COPD. Thus ACO might be defined as an evolving process for which new scientific evidence is still needed to reach definitive conclusions.

Recently, inconsistencies in approaches to ACO proposed in the Spanish reference guidelines for asthma (Spanish Guidelines for the Management of Asthma [GEMA])[4] and for COPD (GesEPOC)[1] have been pointed out in the different scientific respiratory medicine fora.[5] For this reason, on the initiative of the Spanish Society of Pulmonology and Thoracic Surgery (SEPAR), authors representing both guidelines formed a working group with the aim of reaching consensus on a common definition.

Method

This Spanish consensus on ACO was executed by the asthma and COPD special interest groups on the initiative of the SEPAR. The coordinators of GEMA and GesEPOC (VP and MM) convened a group of specialists who were involved in drawing up these guidelines, along with a representative from primary care (MRR) who has experience in ACO.

Firstly, the topics of the consensus were defined: concept and definition, epidemiology, diagnostic confirmation, and treatment. Each topic was reviewed by 2 experts, one GEMA representative and one GesEPOC representative. The most important points in each of the sections were discussed in an in-person meeting, and criteria and a diagnostic algorithm for ACO were agreed upon.

Subsequently, the coordinators prepared a questionnaire in which the key points of the proposal were submitted for consensus. The questionnaire, which was reviewed by the whole group, consisted of 20 questions, statements or claims, and was completed online on the SEPAR website (www.separ.es).

A large group of experts in the area of asthma and/or COPD were invited to participate and were given a copy of the draft consensus document. A total of 44 specialists completed the opinion survey, based partly on the Delphi method.[6,7] Of these, 29 were respiratory medicine experts, 5 allergologists, 5 primary care physicians, and 5 internal medicine physicians.

The respondents had to score their degree of agreement or disagreement with the wording of the question or statement on a 1–7 Likert scale, in such a way that 1 represented the greatest disagreement with the wording, moving progressively to 7, which represented the greatest agreement. Agreement on the question or statement was consensual when the median score was 6 or 7, and disagreement was consensual when the median was 1 or 2. A median of between 3 and 5 signified a neutral opinion, neither agreement nor disagreement. Participants completed the survey in a first round of questions; in a second round, only questions which did not achieve consensual agreement or disagreement in the first round were addressed. Mean values and standard deviation for the results, percentage of agreement and the percentage of responses with a score of 6 or 7 are shown.

Concept and Definition

It is unknown if the overlapping clinical characteristics of COPD and asthma are due to the presence of 2 common diseases in the same patient, or if, in contrast, there is a common underlying pathogenic element. Longitudinal studies recognize childhood asthma as an independent risk factor for developing COPD, particularly when it coincides with smoking.[8] However, more than 100 genes that usually code for a lymphocyte T helper (Th2) immunoinflammatory signal and that have been linked with greater reversibility in bronchodilator tests, peripheral eosinophilia, and better response to treatment with inhaled corticosteroids (ICS), have been identified in patients with well-characterized COPD and no history of asthma.[9] Despite these findings, insufficient evidence is available to claim a common origin, so the best description of the situation of these patients is overlapping asthma and COPD. Thus, the ACO patient group would