

Wakefield and Kirklees Guidelines for Diagnosing COPD in Primary Care

Consider a diagnosis of COPD

- In patients who are
- over 35
 - smokers or ex smokers
 - have any of these symptoms:
 - exertional breathlessness
 - chronic cough
 - regular sputum production
 - frequent winter 'bronchitis'
 - wheeze
 - and have no clinical features of asthma (see table below)

If considering COPD perform spirometry

Airflow obstruction is defined as post bronchodilator
FEV₁/FVC < 0.7
Spirometric reversibility testing is not usually necessary as part of the diagnostic process or to plan initial therapy

If no doubt, diagnose COPD, perform chest x-ray, full blood count, BMI, record MRC Dyspnoea Score and start treatment

If in doubt about diagnosis consider the following pointers

- In patients who are
- Asthma may be present if:
 - there is a >400ml increase in FEV₁ in response to bronchodilators
 - serial peak flow measurements show significant diurnal or day-to-day variability
 - there is a >400ml increase in FEV₁ in response to prednisolone, at least 30mg daily for 2 weeks
 - Clinically significant COPD is not present if FEV₁/FVC ratio returns to normal with drug therapy
 - Refer for more detailed investigations if needed

If still in doubt, make a provisional diagnosis and start empirical treatment

Reassess diagnosis in view of response to treatment

Classification based on FEV₁ % Predicted

Read Code	Mild	80%	Moderate	50%	Severe	30%	Very Severe
Emis	H36		H37		H38		H39
System1	XaEIV		XaEIW		XaEIIY		XaN4a

Clinical features

Differentiating COPD and asthma

	COPD	Asthma
Smoker or ex smoker	nearly all	possibly
Symptoms under age 35	rare	often
Chronic productive cough	common	uncommon
Breathlessness	persistent	variable
Night time waking with breathlessness &/or wheeze	uncommon	common
Significant diurnal or day to day variability of symptoms	uncommon	common

MRC Dyspnoea Score

- Grade degree of breathlessness related to activities
1. Not troubled by breathlessness except on strenuous exercise
 2. Short of breath when hurrying or walking up a slight hill
 3. Walks slower than contemporaries on level ground
 4. Stops for breath after walking about 100m or after a few minutes on level ground
 5. Too breathless to leave the house, or breathless when dressing or undressing

See overleaf for review information and referral criteria

Reasons for Referral to secondary care include

Reason	Purpose of referral
There is diagnostic uncertainty	Confirm diagnosis and optimise therapy
Suspected severe COPD	Confirm diagnosis and consider advanced therapies
The patient requests a second opinion	Confirm diagnosis and optimise therapy
Onset of cor pulmonale	Confirm diagnosis and optimise therapy
Assessment for oxygen therapy	Optimise therapy and measure blood gases
Assessment for long-term nebuliser therapy	Optimise therapy and exclude inappropriate prescriptions
Assessment for oral corticosteroid therapy	Justify need for long-term treatment or supervise withdrawal
Bullous lung disease	Patients with large bullae seen on chest x-ray may benefit from bullectomy
A rapid decline in FEV ₁	This is associated with early mortality and may require early intervention
Assessment for lung volume reduction surgery	Some patients with severe symptoms and no co morbidity and considered fit for major surgery may benefit from LRVS
Assessment for lung transplantation	Considered for patients with advanced disease and no other co morbidities
Dysfunctional breathing/Hyperventilation syndrome/Disproportionate breathlessness	Confirm diagnosis, optimise pharmacotherapy and access other therapists
Aged under 40 years or a family history of alpha ₁ -antitrypsin deficiency	Identify alpha ₁ -antitrypsin deficiency, register for therapy when available and screen family
Symptoms disproportionate to lung function deficit	Look for other explanations
Frequent infections or exacerbations	Consider bronchiectasis and optimise therapy
Haemoptysis	Consider carcinoma of the bronchus and other diagnosis

Decline in FEV₁

Decline in FEV₁ is approximately 20-30ml/yr after the age of 30 in normal non-smoking individuals
In smokers susceptible to developing COPD, the rate may increase to 50-90ml/yr
Rapid decline in FEV₁ can be defined as loss of >100mls/yr