Quality Independent Physicians

STABLE COPD MANAGEMENT STRATEGIES AND CLINICAL GUIDELINES

GOALS:

- Reduce long-term decline in lung function
- Prevent and treat exacerbations
- Reduce hospitalizations and mortality
- Relieve disabling dyspnea
- Improve exercise tolerance and health related quality of live

GUIDELINES:

If has diagnosis of COPD

- FEV1 or FEV1/FVC should be documented on chart
- Should repeat/document updated FEV1 or FEV1/FVC every two years
- If FEV1, FEV1/FVC <50% and patient on maximal therapy/oxygen, there is no need to track further change in FEV1, FEV1/FVC.

Smoking status documented on chart

- If current every day smoker, counseling regarding smoking cessation and education should be provided.

Stable COPD with respiratory symptoms and FEV1 of 60-80% predicted:

- Inhaled bronchodilator may be used (albuterol, levalbuterol, combivent)

Stable COPD with respiratory symptoms and FEV1 <60% predicted:

- Long acting inhaled monotherapy should be used (anti-cholinergics, long acting beta-agonists or corticosteroids)
- Short acting rescue medication should be prescribed for exacerbations
- Combination therapy is acceptable (steroid/beta agonist or anticholinergic and steroid or long acting beta agonist)

Stable COPD with FEV1<50%:

- Obtain resting and ambulatory oxygen saturation
  - Severe resting hypoxemia (02 sat <88%) should be treated with supplemental oxygen therapy
- Obtain overnight oximetry
  - Provide nocturnal oxygen if patient qualifies

Chronic Obstructive Pulmonary Disease Program will be reviewed with patient yearly

Consideration but not mandatory guideline:

- Pulmonary rehabilitation for FEV1 <50% or for symptomatic patients with FEV1>50% despite adherence to above treatments