

Barcelona
19 d' Octubre
de 2017

CLÍNIC
BARCELONA
Hospital Universitari

Actualització en el maneig pràctic dels pacients amb bronquièctasis no fibrosi quística

VIII JORNADES D'ATENCIÓ COMPARTIDA EN
PNEUMOLOGIA AIS BARCELONA ESQUERRA

DIRECCIÓ DEL CURS

Dr. Nestor Soler

Servei de Pneumologia, Institut
Clínic Respiratori, Hospital Clínic

 Aula Clínic

12.00– 13.00 h

**NOUS ESQUEMES DE
TRACTAMENT BRONCODILATADOR
EN LA MPOC ESTABLE: DE
L'EVIDENCIA A LA PRÀCTICA CLÍNICA**

Moderadors

Taula redona pro-contra

Josep E. Boada, Carmen Vázquez

Metge Atenció Primària

Pere J Simonet

Metge Especialista Hospital
Àlvar Agustí

Farmacòleg Atenció Primària

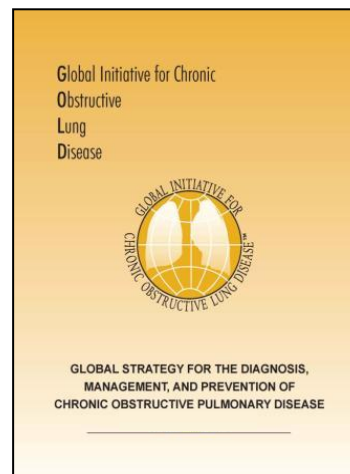
Gladys Benhadam

13.00– 13.15 h

DISCUSSIÓ

Conflictes d'interés

Research grants/clinical trials:	AstraZeneca, GSK, Menarini
Lector for:	AstraZeneca, Boheringer-Ingelheim, Chiesi, Menarini, Teva, Novartis
Member of scientific (advisory) board:	AstraZeneca, Boheringer-Ingelheim, Chiesi, Novartis
Consultant:	None
Employer (including part-time):	None
Tobacco Industry relationship:	None

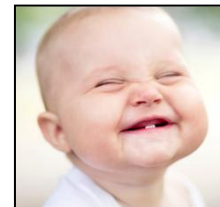


Broncodilatadors a la MPOC estable



En teoria, la teoria i la practica son el mateix

A la practica ... no!



Broncodilatadors a la MPOC estable



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NEWS & EVENTS

SIGN UP FOR THE 2017 WORLD
COPD DAY CONFERENCE

November 15, 2017



READ THE LATEST
NEWSLETTER HERE
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WORLD COPD DAY 2017

THE THEME FOR 2017 WORLD COPD DAY IS
"THE MANY FACES OF COPD".

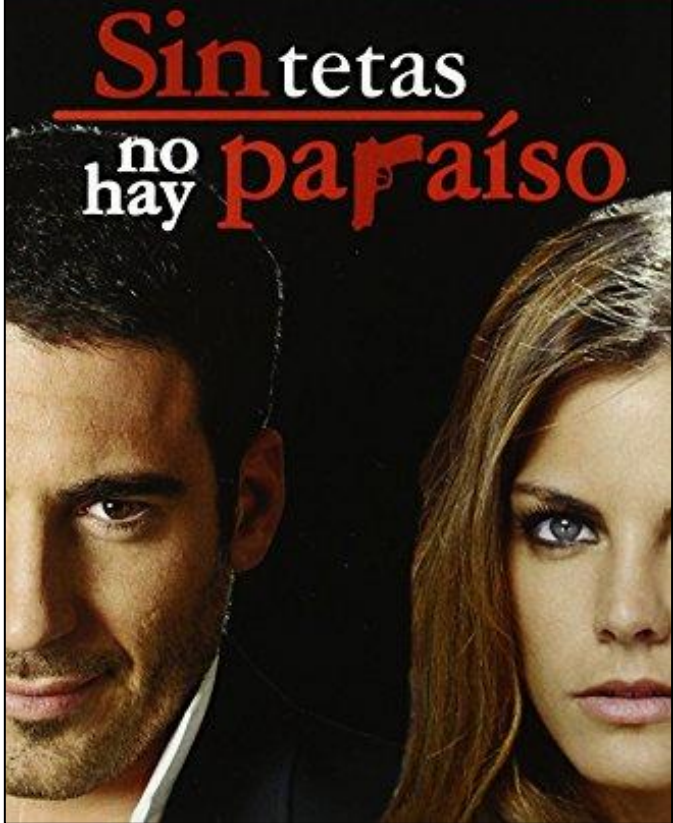


Tractament broncodilatador
(+ no tabac, activitat física, vacunes, comorbiditats)

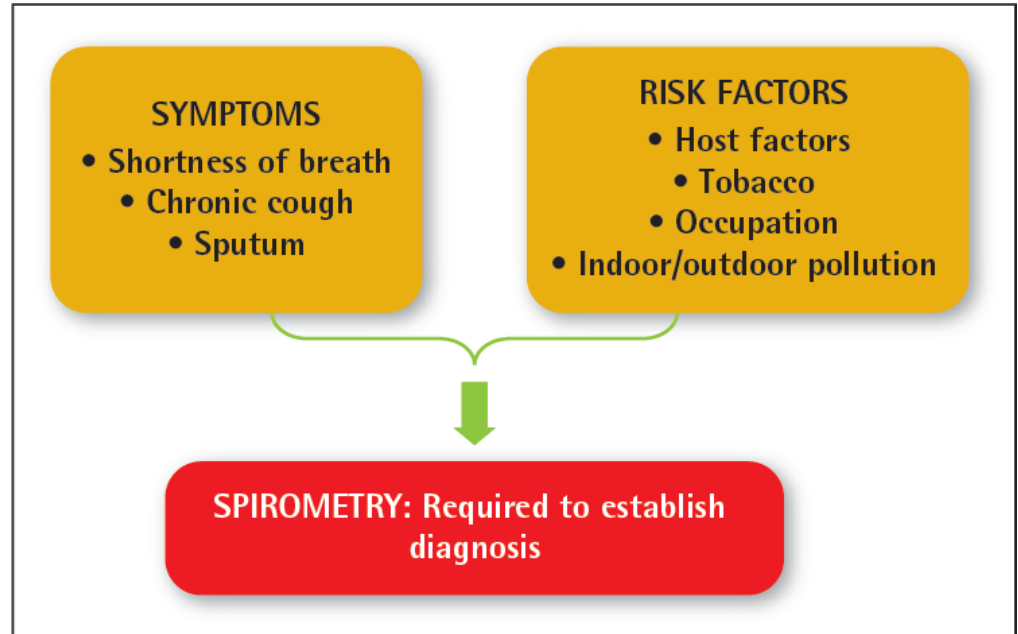
clau

pero

- Diagnòstic (diferencial)
- Objectius terapèutics
- Individualització del tractament
 - Fàrmac(s)
 - Dispositiu i tècnica inhalatoria



Sense espirometria no hi ha diagnòstic d'MPOC



Grade	FEV ₁ (% predicted)
GOLD 1	≥ 80
GOLD 2	50-79
GOLD 3	30-49
GOLD 4	< 30

Post-bronchodilator FEV₁/FVC < 0.70 confirms the presence of persistent airflow limitation



Differential Diagnosis

Table 2.7. Differential diagnosis of COPD

Diagnosis	Suggestive Features
COPD	Onset in mid-life. Symptoms slowly progressive. History of tobacco smoking or exposure to other types of smoke.
Asthma	Onset early in life (often childhood). Symptoms vary widely from day to day. Symptoms worse at night/early morning. Allergy, rhinitis, and/or eczema also present. Family history of asthma. Obesity coexistence.
Congestive Heart Failure	Chest X-ray shows dilated heart, pulmonary edema. Pulmonary function tests indicate volume restriction, not airflow limitation.
Bronchiectasis	Large volumes of purulent sputum. Commonly associated with bacterial infection. Chest X-ray/CT shows bronchial dilation, bronchial wall thickening.
Tuberculosis	Onset all ages. Chest X-ray shows lung infiltrate. Microbiological confirmation. High local prevalence of tuberculosis.
Obliterative Bronchiolitis	Onset at younger age, nonsmokers. May have history of rheumatoid arthritis or acute fume exposure. Seen after lung or bone marrow transplantation. CT on expiration shows hypodense areas.
Diffuse Panbronchiolitis	Predominantly seen in patients of Asian descent. Most patients are male and nonsmokers. Almost all have chronic sinusitis. Chest X-ray and HRCT show diffuse small centrilobular nodular opacities and hyperinflation.
<p><i>These features tend to be characteristic of the respective diseases, but are not mandatory. For example, a person who has never smoked may develop COPD (especially in the developing world where other risk factors may be more important than cigarette smoking); asthma may develop in adult and even in elderly patients.</i></p>	



Table 4.1. Goals for treatment of stable COPD

- **Relieve symptoms**
- **Improve exercise tolerance**
- **Improve health status**



REDUCE SYMPTOMS

and

- **Prevent disease progression**
- **Prevent and treat exacerbations**
- **Reduce mortality**

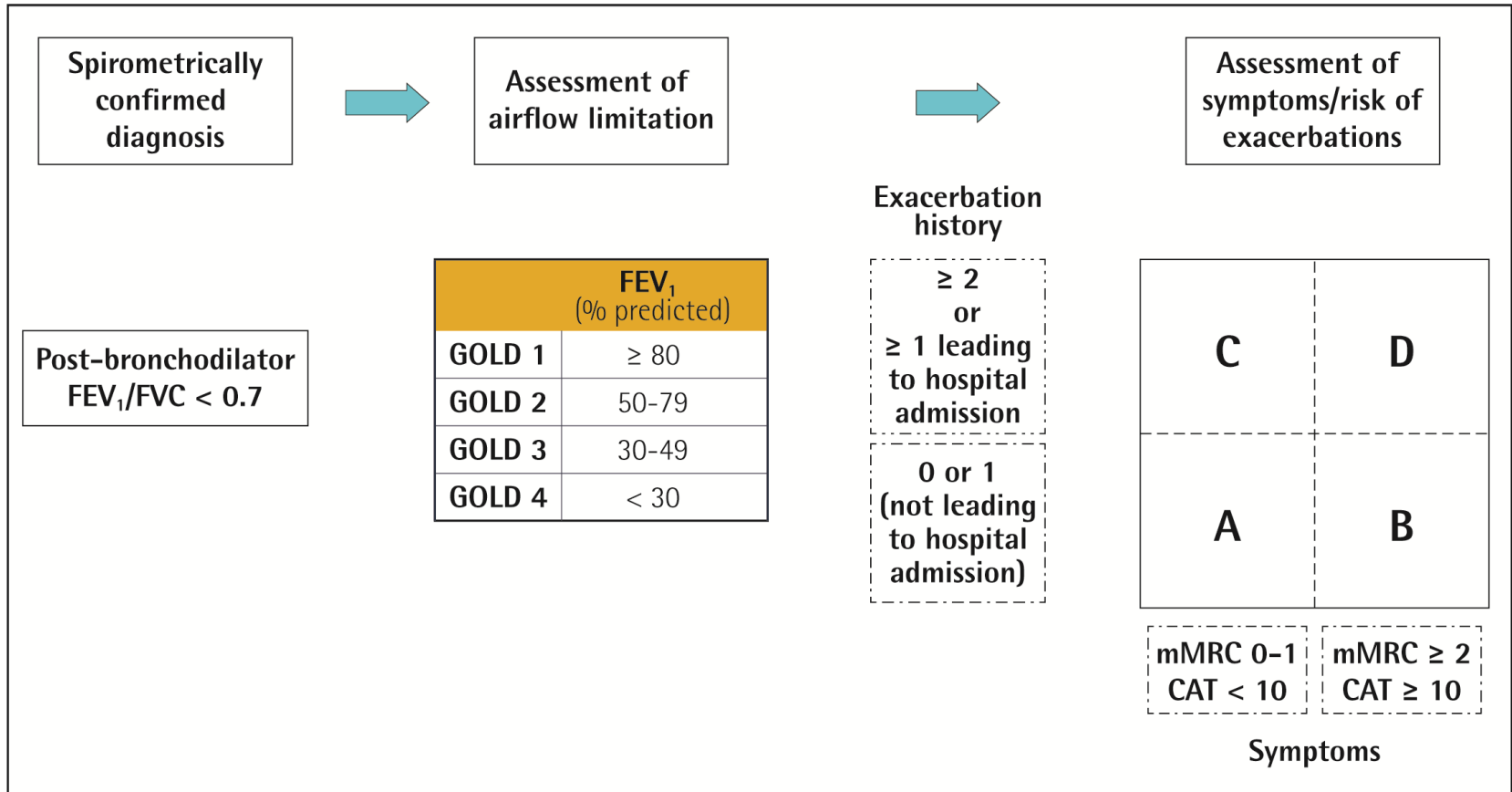


REDUCE RISK



ABCD Assessment Tool 2017

Figure 2.4. The refined ABCD assessment tool



Spirometry {
Diagnosis
Prognosis
Follow-up
Non-pharmacological tx

ABCD {
Initial Pharmacological tx
Follow-up

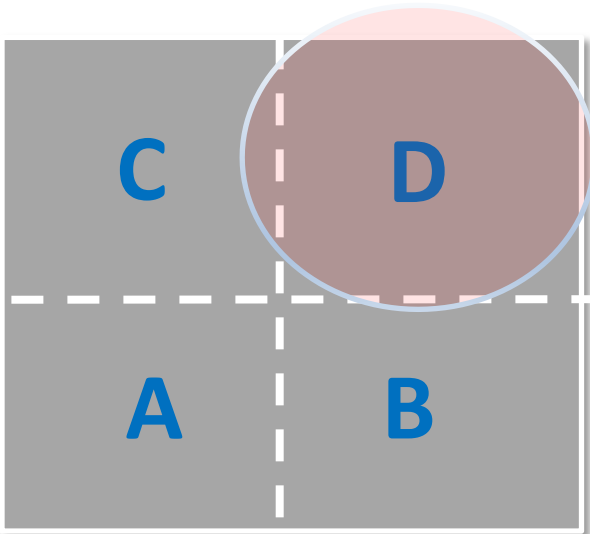
Example: Consider Two Patients

- Both with $FEV_1 < 30\%$ and CAT scores of 18
- One no AECOPD / the other 3 AECOPD

(GOLD 2011)

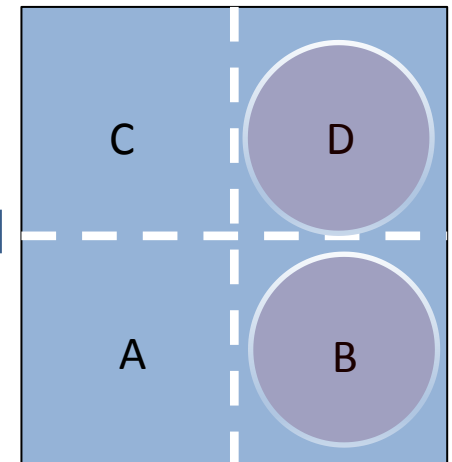


(GOLD 2017)

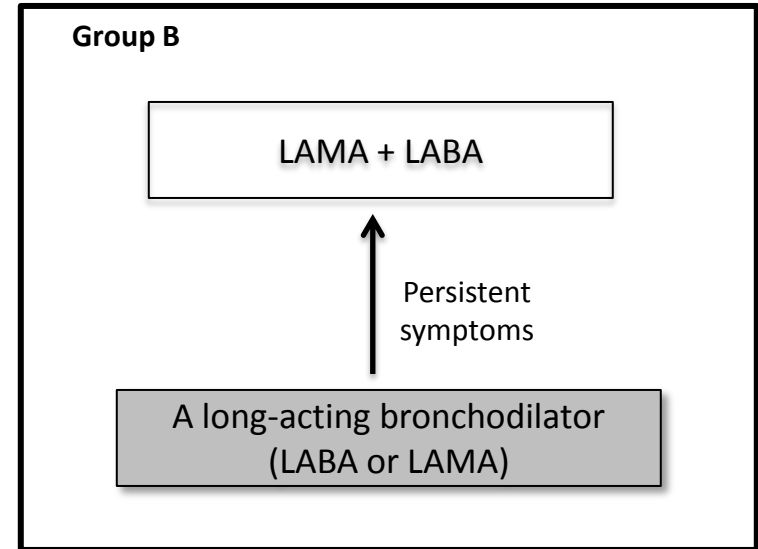
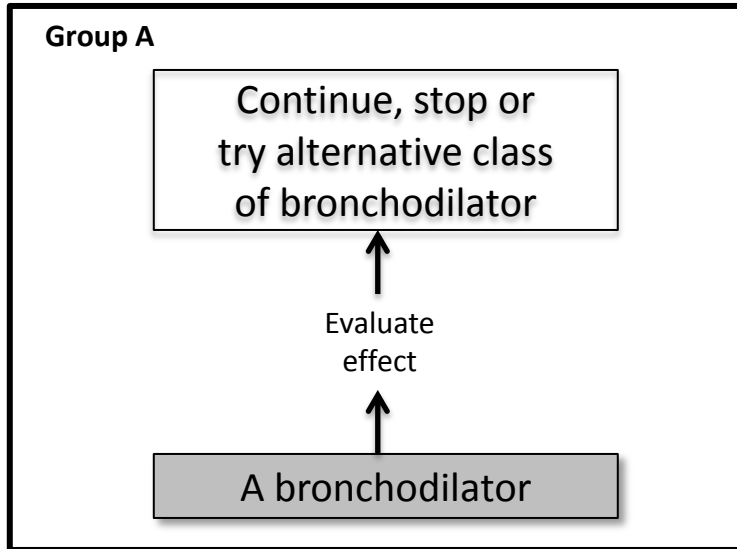
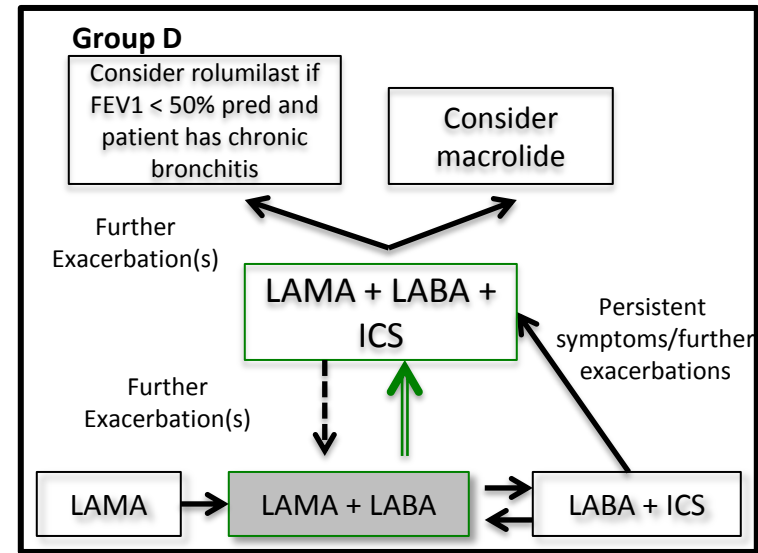
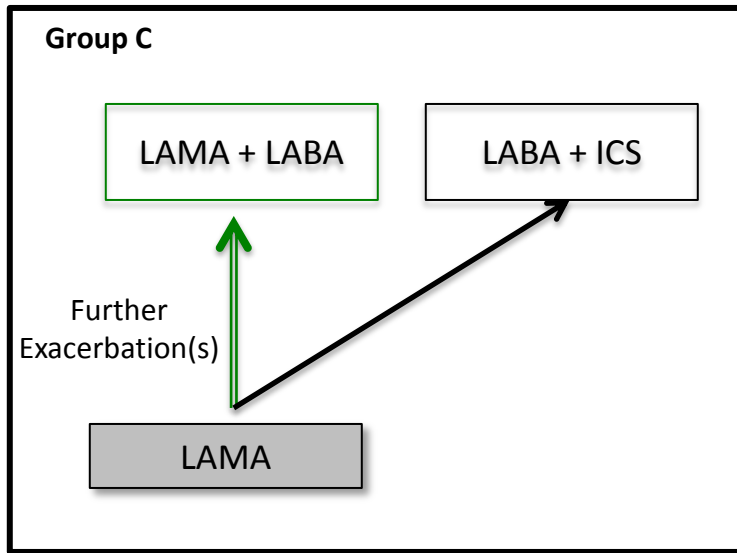


Both labelled GOLD D in prior classification scheme

Grade	FEV_1 (% pred.)
1	≥ 80
2	50-79
3	30-49
4	< 30



3 AECOPDs - GOLD 4, Category D
No AECOPDs - GOLD 4, Category B



mMRC 0-1
CAT < 10

mMRC 2+
CAT 10+

≥ 2 ECOPD or
≥1 leading
to hospitalization

0 or 1 ECOPD
(not leading
to hospital
admission)

Broncodilatadors a la MPOC estable



En teoria, la teoria i la practica son el mateix

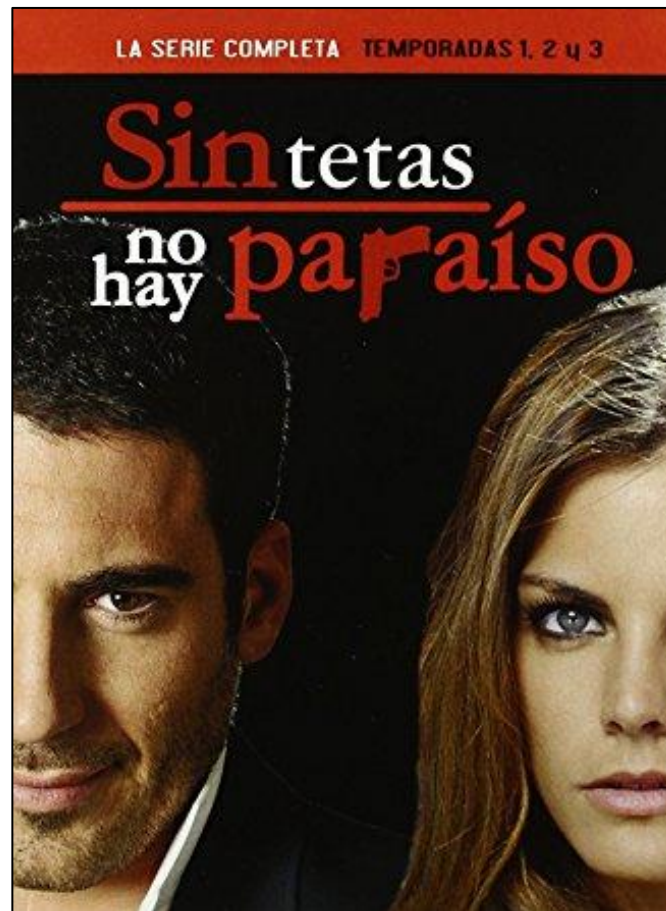
A la practica ... no!



Practica clinica

Practica clinica

- Diagnòstic correcte



Practica clinica

- Diagnòstic correcte
- Deixar de fumar, activitat física, vacunacions



Practica clinica

- Diagnòstic correcte
- Deixar de fumar, activitat física, vacunacions
- Curta o llarga durada?

Practica clinica

- Diagnòstic correcte
- Deixar de fumar, activitat física, vacunacions
- Curta o llarga durada?
- Un o dos broncodilatadors?

Practica clinica

- Diagnòstic correcte
- Deixar de fumar, activitat física, vacunacions
- Curta o llarga durada?
- Un o dos broncodilatadors?
- Per quin començo: LABA o LAMA?

Practica clinica

- Diagnòstic correcte
- Deixar de fumar, activitat física, vacunacions
- Curta o llarga durada?
- Un o dos broncodilatadors?
- Per quin començo: LABA o LAMA?
- **c/24 o c/12 h?**

Practica clinica

- Diagnòstic correcte
- Deixar de fumar, actiu
- Curta o llarga durada?
- Un o dos broncodilatadors
- Per quin començo: LAE
- c/24 o c/12 h?
- Quin dispositiu?





Moltes gracies per la vostra atenció

Alvar Agusti

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