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A Society of health professionals committed to improving care for patients with lung diseases, through education, research and improving standards

BRIEFING PAPER ON CHRONIC OBSTRUCTIVE PULMONARY DISEASE

What is COPD?

COPD stands for Chronic Obstructive Pulmonary Disease. This is a term used for a number of conditions; including chronic bronchitis and emphysema. COPD leads to damaged airways in the lungs, causing them to become narrower and making it harder for air to get in and out of the lungs.

The most common cause of COPD is smoking. Occupational factors, such as coal dust, and some inherited problems can also cause COPD. Pollution as a factor is currently under investigation.

What are the symptoms?

- Persistent smokers cough
- Frequent production of phlegm
- Breathlessness on mild exertion
- Frequent coughs and colds in winter

Can COPD be treated?

COPD cannot be cured once you have it, but treatments may help prevent lung function from deteriorating further. The earlier COPD symptoms are treated the better. Some patients are given medicine - usually by inhalers called bronchodilators that help to make the airways wider.

Giving up smoking gradually reduces the chances of getting COPD and can slow down its progress if a patient has already developed the condition. Patients are also advised to keep as mobile as possible, look after their weight and eat a balanced diet.

Pulmonary rehabilitation has also been proven to help people suffering from COPD. Pulmonary rehabilitation is a course of tailored exercise that helps those with a lung condition make better use of their lungs.

Clinical trials have shown that pulmonary rehabilitation can have a significant benefit on a patient's health and improve their quality of life. These benefits include:

- Individually prescribed training
- Exercise capacity
- Physical endurance
- Reduced breathlessness
- Improved self-esteem and independence

Pulmonary rehabilitation programmes, whilst individually tailored to each patient, take place in a group setting, which allows patients to form friendships and share experiences with others. The programme not only offers physical training, but also provides advice on lung health, social and psychological support.

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Not only does pulmonary rehabilitation benefit patients but it also has a significant impact on the NHS by reducing GP home visits and reducing days spent in hospital. The cost outlay in providing the service is easily offset by the reduction in health service utilisation. It is reasonable to conclude that pulmonary rehabilitation is cost effective and results in financial benefits to the health service

The important issue is not only the provision of pulmonary rehabilitation, but patient access to these programmes. BTS and British Lung Foundation research estimates that approximately 10,000 patients per year have access to a local pulmonary rehabilitation programme. When we compare this number to the 600,000 patients diagnosed with COPD in the UK it tells us that only 1.7% of the total patients diagnosed with COPD have access to pulmonary rehabilitation each year.

The burden of COPD

- Here in the UK, COPD is responsible for the deaths of 30,000 people each year
- By 2020 COPD is predicted to be the third biggest killer in the world and will be responsible for the deaths of over six million people
- COPD is poised to kill more women in the UK than breast cancer in 2005
- COPD is a major cause of medical admissions, particular in winter. It is estimated that there are 308,355 emergency medical admissions per year in the UK for COPD
- COPD accounts for more than 10% of all acute admissions, which should make it a priority area for all hospitals concerned with effective management of acute medical admissions
- Of those that are admitted to hospital for COPD, 1 in 10 will die in hospital, one in three will die within six months, and 43% will die within twelve months of their admission to hospital¹
- In 2000/01 – 2001/02 in Colchester there were 520 admissions for COPD, taking up 4,156 bed days costing £1,134,588²

The case for an NSF

- COPD and asthma disproportionately affect those from lower socio-economic classes. King's Fund analysis³ showed that 31% of medical admissions for COPD are associated with deprivation³
- Care and treatment services provided in the community measurably benefit patients with COPD – these are currently patchy across the UK, however. A recent study found that such programmes maintained a significant reduction in hospitalisations after a two-year period. Hospitalisations fell by 26.9% and emergency visits fell by 21.1%⁴
- Early Discharge Schemes reduce length of stay in hospital and have been shown to be safe for selected patients with COPD
- Results of the 2nd UK COPD Audit on the efficacy and organisation of Early Discharge Schemes for acute exacerbations of COPD (AECOPD) were presented last week at the BTS Winter Meeting⁵
- Results showed that about 30% of patients admitted to hospital with AECOPD appear to be suitable for early discharge, which is safe and effective

¹ Breathing Fear, The COPD effect, BLF, November 2003

² King's Fund report, COPD medical admissions in the UK 2000/01 – 2001/02

³ King's Fund report, COPD medical admissions in the UK 2000/01 – 2001/02

⁴ (Gadoury MA, Schwartzman K, Rouleau M, Maltais F, Julien M, Beaupre A, Renzi P, Begin R, Nault D, Bourbeau J; Eur Respir J. 2005 Nov;26(5):853-7).

⁵ Analysis from the 2nd UK COPD audit. S. J. Quantrill, H. Hosker, K. Anstey, D. Lowe, C. M. Roberts. Royal College of Physicians Clinical Effectiveness Unit

- The audit also found that there is at least a three- day reduction in the length of stay for patients on EDS

However, most units in 2003 still did not have EDS and there is wide variation in practice across the country, with the best type of scheme still unknown

Of the 233 hospitals surveyed only 44% have access to EDS. Those hospitals with EDS didn't necessarily operate them round the clock:

- 94% ran EDS for seven hours or more per day
 - 64% provided a five day service
 - Only one quarter ran a seven day service
- Overall, better funded diagnostic, treatment and care services for COPD - such as spirometry (a crucial breathing test), NIV (non invasive ventilation), Early Discharge Systems and pulmonary rehabilitation - would increase the number of people quitting smoking, improve patient health and reduce hospital admissions and unnecessary treatments. In addition, the lack of an NSF specifying uniform and expected standards of care means that people from poorer backgrounds are hit hardest
 - An NSF would encourage PCTs and Trusts to work together to provide much greater availability of these services and to implement clinical guidelines for COPD and asthma