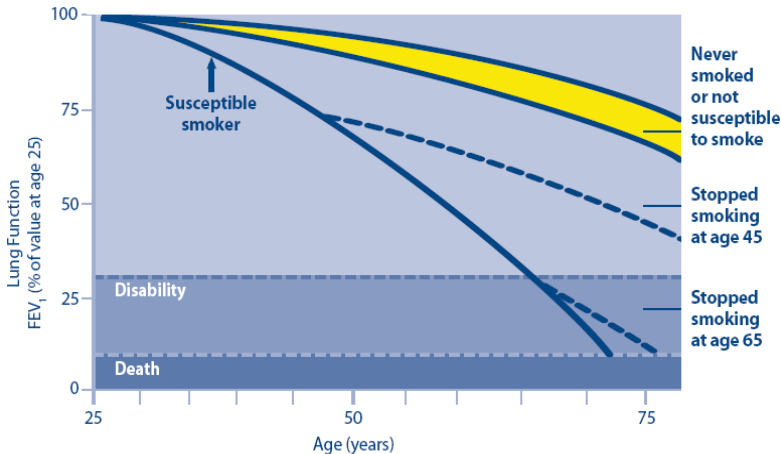


Smoking and decline in lung function in COPD

This figure shows the rate of loss of FEV₁ for a non-smoker compared to a susceptible smoker, the onset of symptoms and disability, and the potential effect of stopping smoking early or late in the course of COPD. As shown, symptoms may not occur until a relatively advanced reduction in lung function.



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Figure adapted from: Fletcher C and Peto R. The natural history of chronic airflow obstruction. *BMJ* 1977;1:1645-1648.

These are general recommendations only; specific clinical decisions should be made by the treating physician based on an individual patient's clinical condition.

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Algorithm for the use of bronchodilator and inhaled corticosteroid (ICS) therapy in COPD

Intermittent symptoms (e.g. cough, exertional dyspnea)

Short acting agent p.r.n (inhaled β -agonist, or anticholinergic, or both)

If persistent symptoms

Add standing long-acting agent (inhaled β -agonist or anticholinergic) to p.r.n short-acting agent

If limited benefit*

Add or substitute alternate class of long-acting bronchodilator and/or add standing ICS

If limited benefit*

Consider oral theophylline

Notes:

If FEV₁ is <50% predicted and exacerbations of COPD occur at least once within a year, consider adding standing ICS.

Always ensure the patient can use an inhaled device effectively and understands its purpose.

*Assessment of benefit

- Has your treatment helped you?
- Is your breathing easier in any way?
- Can you do some things now that you couldn't do before or do the same things faster?
- Do you get less breathless when you are doing the things you did before?
- Has your sleep improved?

Algorithm based on: Celli BR, MacNee W. Standards for the diagnosis and treatment of patients with COPD: a summary of the ATS/ERS position paper. *European Respiratory Journal* 2004;23(6):932-946.