

Diagnosis of Diseases of
Chronic Airflow Limitation:

Asthma COPD and Asthma - COPD Overlap Syndrome (ACOS)



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**Based on the Global Strategy for Asthma
Management and Prevention and the Global Strategy
for the Diagnosis, Management and Prevention of
Chronic Obstructive Pulmonary Disease.**

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Diagnosis of Diseases of Chronic Airflow Limitation: Asthma, COPD and Asthma-COPD Overlap Syndrome (ACOS)

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PREFACE

In children and young adults, the differential diagnosis in patients with respiratory symptoms is different from that in older adults. Once infectious disease and non-pulmonary conditions (e.g. congenital heart disease, vocal cord dysfunction) have been excluded, the most likely chronic airway disease in children is asthma. This is often accompanied by allergic rhinitis. In adults (usually after the age of 40 years) COPD becomes more common, and distinguishing asthma with chronic airflow limitation from COPD becomes problematic.¹⁻⁴

A significant proportion of patients who present with symptoms of a chronic airways disease have features of both asthma and COPD.⁵⁻⁹ Several diagnostic terms, most including the word 'overlap', have been applied to such patients, and the topic has been extensively reviewed.^{4,6,10,11} However, there is no generally agreed term or defining features for this category of chronic airflow limitation, although a definition based upon consensus has been published for overlap in patients with existing COPD.¹²

In spite of these uncertainties, there is broad agreement that patients with features of both asthma and COPD experience frequent exacerbations,⁶ have poor quality of life, a more rapid decline in lung function and high mortality,^{6,13} and consume a disproportionate amount of healthcare resources¹⁴ than asthma or COPD alone. In these reports, the proportion of patients with features of both asthma and COPD is unclear and will have been influenced by the inclusion criteria used. However, prevalence rates between 15 and 55% have been reported, with variation by gender and age.^{8,13,15} Concurrent doctor-diagnosed asthma and COPD has been reported in between 15 and 20% of patients.^{7,10,16,17}

This document has been developed by the Science Committees of both GINA and GOLD, based on a detailed review of available literature and consensus. It provides an approach to distinguishing between asthma, COPD and the overlap of asthma and COPD, for which the term Asthma COPD Overlap Syndrome (ACOS) is proposed¹⁰ Rather than attempting a formal definition of ACOS, this document presents features that identify and characterize ACOS, ascribing equal weight to features of asthma and of COPD. A simple approach to initial treatment of ACOS is also included. It is acknowledged that within this description of ACOS will lie a number of phenotypes that may in due course be identified by more detailed characterization on the basis of clinical, pathophysiological and genetic identifiers.¹⁸⁻²⁰ The primary objective of this approach is to inform clinical practice, based on current evidence.

Diagnosis Of Diseases Of Chronic Airflow Limitation: Asthma, COPD and Asthma–COPD Overlap Syndrome

A joint project of GINA and GOLD[#]

KEY POINTS

- Distinguishing asthma from COPD can be problematic, particularly in smokers and older adults
- ACOS is identified by the features that it shares with both asthma and COPD.
- A stepwise approach to diagnosis is advised, comprising recognition of the presence of a chronic airways disease, syndromic categorization as asthma, COPD or the overlap between asthma and COPD (the Asthma COPD Overlap Syndrome (ACOS)), confirmation by spirometry and, if necessary, referral for specialized investigations.
- Although initial recognition and treatment of ACOS may be made in primary care, referral for confirmatory investigations is encouraged, as outcomes for ACOS are often worse than for asthma or COPD alone.
- Initial treatment should be selected to ensure that:
 - o Patients with features of asthma receive adequate controller therapy including inhaled corticosteroids, but not long-acting bronchodilators alone (as monotherapy), and
 - o Patients with COPD receive appropriate symptomatic treatment with bronchodilators or combination therapy, but not inhaled corticosteroids alone (as monotherapy).
- The consensus-based description of the Asthma COPD Overlap Syndrome (ACOS) is intended to stimulate further study of the character and treatments for this common clinical problem.

OBJECTIVE

This consensus-based document aims to assist clinicians to:

- Identify patients who have a disease of chronic airflow limitation
- Distinguish asthma from COPD and the Asthma-COPD Overlap Syndrome (ACOS)
- Decide on initial treatment and/or need for referral

[#] This chapter is excerpted from the Global Strategy for Asthma Management and Prevention, 2014. The full report can be viewed at <http://www.ginasthma.org>

DEFINITIONS

Table 1. Current definitions of asthma and COPD, and clinical description of ACOS

| |
|--|
| <p style="text-align: center;">Asthma</p> <p>Asthma is a heterogeneous disease, usually characterized by chronic airway inflammation. It is defined by the history of respiratory symptoms such as wheeze, shortness of breath, chest tightness and cough that vary over time and in intensity, together with variable expiratory airflow limitation. [GINA 2014]</p> |
| <p style="text-align: center;">COPD</p> <p>COPD is a common preventable and treatable disease, characterized by persistent airflow limitation that is usually progressive and associated with enhanced chronic inflammatory responses in the airways and the lungs to noxious particles or gases. Exacerbations and comorbidities contribute to the overall severity in individual patients. [GOLD 2014]²¹</p> |
| <p style="text-align: center;">Asthma-COPD Overlap Syndrome (ACOS) – a description for clinical use</p> <p>Asthma-COPD overlap syndrome (ACOS) is characterized by persistent airflow limitation with several features usually associated with asthma and several features usually associated with COPD. ACOS is therefore identified by the features that it shares with both asthma and COPD.</p> |

A summary of the typical characteristics of asthma, COPD and ACOS is presented in Table 2a, showing the similarities and differences in history and investigations.

STEP-WISE APPROACH TO DIAGNOSIS OF PATIENTS WITH RESPIRATORY SYMPTOMS

Step 1: Does the patient have chronic airways disease?

A first step in diagnosing these conditions is to identify patients at risk of, or with significant likelihood of having chronic airways disease, and to exclude other potential causes of respiratory symptoms. This is based on a detailed medical history, physical examination, and other investigations.^{3,22-24}

Clinical history

Features that should prompt consideration of chronic airways disease include:

- History of chronic or recurrent cough, sputum production, dyspnea, or wheezing; or repeated acute lower respiratory tract infections
- Report of a previous doctor diagnosis of asthma or COPD
- History of prior treatment with inhaled medications
- History of smoking tobacco and/or other substances
- Exposure to environmental hazards, e.g. occupational or domestic exposures to airborne pollutants

Physical examination

- May be normal
- Evidence of hyperinflation and other features of chronic lung disease or respiratory insufficiency
- Abnormal auscultation (wheeze and/or crackles)

Radiology

- May be normal, particularly in early stages
- Abnormalities on chest X-ray or CT scan (performed for other reasons such as screening for lung cancer), including hyperinflation, airway wall thickening, air trapping, hyperlucency, bullae or other features of emphysema.
- May identify an alternative diagnosis, including bronchiectasis, evidence of lung infections such as tuberculosis, interstitial lung diseases or cardiac failure.

Screening questionnaires

Many screening questionnaires have been proposed to help the clinician identifying subjects at risk of chronic airways disease, based on the above risk factors and clinical features.²⁵⁻²⁷ These questionnaires are usually context-specific, so they are not necessarily relevant to all countries (where risk factors and comorbid diseases differ), to all practice settings and uses (population screening versus primary or secondary care), or to all groups of patients (case-finding versus self-presenting with respiratory symptoms versus referred consultation). Examples of these questionnaires are provided on both the GINA and GOLD websites.

STEP 2. The syndromic diagnosis of asthma, COPD and ACOS in an adult patient

Given the extent of overlap between features of asthma and COPD (Table 2a), the approach proposed focuses on the features that are most helpful in distinguishing asthma and COPD (Table 2b).

a. Assemble the features that favor a diagnosis of asthma or of COPD

From a careful history that considers age, symptoms (in particular onset and progression, variability, seasonality or periodicity and persistence), past history, social and occupational risk factors including smoking history, previous diagnoses and treatment and response to treatment, the features favoring the diagnostic profile of asthma or of COPD can be assembled. The check boxes in Table 2b can be used to identify the features that are most consistent with asthma and/or COPD. Note that not all of the features of asthma and COPD are listed, but only those that most easily distinguish between asthma and COPD.

b. Compare the number of features in favor of a diagnosis of asthma or a diagnosis of COPD

From Table-2b, count the number of checked boxes in each column. Having several (three or more) of the features listed for either asthma or for COPD, in the absence of those for the alternative diagnosis, provides a strong likelihood of a correct diagnosis.²⁷ However, the absence of any of these features has less predictive value, and does not rule out the diagnosis of either disease. For example, a history of allergies increases the probability that respiratory symptoms are due to asthma, but is not essential for the diagnosis of asthma since non-allergic asthma is a well-recognized asthma phenotype; and atopy is common in the general population including in patients who develop COPD in later years. When a patient has similar numbers of features of both asthma and COPD, the diagnosis of ACOS should be considered.

c. Consider the level of certainty around the diagnosis of asthma or COPD, or whether there are features of both suggesting Asthma-COPD Overlap Syndrome

In the absence of pathognomonic features, clinicians recognize that diagnoses are made on the weight of evidence, provided there are no features that clearly make the diagnosis untenable. Clinicians are able to provide an estimate of their level of certainty and factor it into their decision to treat. Doing so consciously may assist in the selection of treatment and, where there is significant doubt, it may direct therapy towards the safest option - namely, treatment for the condition that should not be missed and left untreated.

Table 2a. Usual features of asthma, COPD and ACOS

| Table 2a. Usual features of asthma, COPD and ACOS | | | | Table 2b. Features that favor asthma or COPD | |
|--|--|---|--|--|---|
| Feature | Asthma | COPD | ACOS | Favors Asthma | Favors COPD |
| <i>Age of onset</i> | Usually childhood onset but can commence at any age. | Usually > 40 years of age | Usually age ≥40 years, but may have had symptoms in childhood or early adulthood | <input type="checkbox"/> Onset before age 20 years | <input type="checkbox"/> Onset after age 40 years |
| <i>Pattern of respiratory symptoms</i> | Symptoms may vary over time (day to day, or over longer periods), often limiting activity. Often triggered by exercise, emotions including laughter, dust or exposure to allergens | Chronic usually continuous symptoms, particularly during exercise, with 'better' and 'worse' days | Respiratory symptoms including exertional dyspnea are persistent but variability may be prominent | <input type="checkbox"/> Variation in symptoms over minutes, hours or days <input type="checkbox"/> Symptoms worse during the night or early morning <input type="checkbox"/> Symptoms triggered by exercise, emotions including laughter, dust or exposure to allergens | <input type="checkbox"/> Persistence of symptoms despite treatment <input type="checkbox"/> Good and bad days but always daily symptoms and exertional dyspnea <input type="checkbox"/> Chronic cough and sputum preceded onset of dyspnea, unrelated to triggers |
| <i>Lung function</i> | Current and/or historical variable airflow limitation, e.g. BD reversibility, AHR | FEV ₁ may be improved by therapy, but post-BD FEV ₁ /FVC < 0.7 persists | Airflow limitation not fully reversible, but often with current or historical variability | <input type="checkbox"/> Record of variable airflow limitation (spirometry, peak flow) | <input type="checkbox"/> Record of persistent airflow limitation (post-bronchodilator FEV ₁ /FVC < 0.7) |
| <i>Lung function between symptoms</i> | May be normal between symptoms | Persistent airflow limitation | Persistent airflow limitation | <input type="checkbox"/> Lung function normal between symptoms | <input type="checkbox"/> Lung function abnormal between symptoms |
| <i>Past history or family history</i> | Many patients have allergies and a personal history of asthma in childhood, and/or family history of asthma | History of exposure to noxious particles and gases (mainly tobacco smoking and biomass fuels) | Frequently a history of doctor-diagnosed asthma (current or previous), allergies and a family history of asthma, and/or a history of noxious exposures | <input type="checkbox"/> Previous doctor diagnosis of asthma <input type="checkbox"/> Family history of asthma, and other allergic condition | <input type="checkbox"/> Previous doctor diagnosis of COPD, chronic bronchitis or emphysema <input type="checkbox"/> Heavy exposure to a risk factor: tobacco smoke, biomass fuels |
| <i>Time course</i> | Often improves spontaneously or with treatment, but may result in fixed airflow limitation | Generally, slowly progressive over years despite treatment | Symptoms are partly but significantly reduced by treatment. Progression is usual and treatment needs are high | <input type="checkbox"/> No worsening of symptoms over time. Symptoms vary either seasonally, or from year to year <input type="checkbox"/> May improve spontaneously or have an immediate response to BD or to ICS over weeks | <input type="checkbox"/> Symptoms slowly worsening over time (progressive course over years) <input type="checkbox"/> Rapid-acting bronchodilator treatment provides only limited relief. |
| <i>Chest X-ray</i> | Usually normal | Severe hyperinflation & other changes of COPD | Similar to COPD | <input type="checkbox"/> Normal | <input type="checkbox"/> Severe hyperinflation |
| <i>Exacerbations</i> | Exacerbations occur, but the risk of exacerbations can be considerably reduced by treatment | Exacerbations can be reduced by treatment. If present, comorbidities contribute to impairment | Exacerbations may be more common than in COPD but are reduced by treatment. Comorbidities can contribute to impairment | *Syndromic diagnosis of airways disease: how to use Table 2b Shaded columns list features that, when present, best distinguish between asthma and COPD. For a patient, count the number of check boxes in each column. If three or more boxes are checked for either asthma or COPD, that diagnosis is suggested. If there are similar numbers of checked boxes in each column, the diagnosis of ACOS should be considered. See Step 2 for more details. | |
| <i>Typical airway inflammation</i> | Eosinophils and/or neutrophils | Neutrophils in sputum, lymphocytes in airways, may have systemic inflammation | Eosinophils and/or neutrophils in sputum. | | |

STEP 3: Spirometry

Spirometry is essential for the assessment of patients with suspected chronic disease of the airways. It must be performed at either the initial or a subsequent visit, if possible before and after a trial of treatment. Early confirmation or exclusion of the diagnosis may avoid needless trials of therapy, or delays in initiating other investigations. Spirometry confirms chronic airflow limitation but is of more limited value in distinguishing between asthma with fixed airflow obstruction, COPD and ACOS (Table 3).

Measurement of peak expiratory flow (PEF), although not an alternative to spirometry, if performed repeatedly on the same meter over a period of 1–2 weeks may help to confirm the diagnosis of asthma by demonstrating excessive variability, but a normal PEF does not rule out either asthma or COPD. A high level of variability in lung function may also be found in ACOS.

After the results of spirometry and other investigations are available, the provisional diagnosis from the syndrome-based assessment must be reviewed and, if necessary, revised. As shown in Table 3, spirometry at a single visit is not always confirmatory of a diagnosis, and results must be considered in the context of the clinical presentation, and whether treatment has been commenced. Inhaled corticosteroids and long-acting bronchodilators influence results, particularly if a long withhold period is not used prior to performing spirometry. Further tests might therefore be necessary either to confirm the diagnosis or to assess the response to initial and subsequent treatment.

STEP 4: Commence initial therapy

Faced with a differential diagnosis equally balanced between asthma and COPD (i.e. ACOS) the default position should be to start treatment accordingly for asthma (Table 4). This recognizes the pivotal role of ICS in preventing morbidity and even death in patients with uncontrolled asthma symptoms, for whom even seemingly 'mild' symptoms (compared to those of moderate or severe COPD) might indicate significant risk of a life-threatening attack¹⁰.

- If the syndromic assessment suggests asthma or ACOS, or there is significant uncertainty about the diagnosis of COPD, it is prudent to start treatment as for asthma until further investigation has been performed to confirm or refute this initial position.
 - o Treatments will include an ICS (in a low or moderate dose, depending on level of symptoms).
 - o A long-acting beta2-agonist (LABA) should also be continued (if already prescribed), or added. However, it is important that patients should not be treated with a LABA without an ICS (often called LABA monotherapy) if there are features of asthma.
- If the syndromic assessment suggests COPD, appropriate symptomatic treatment with bronchodilators or combination therapy should be commenced, but not ICS alone (as monotherapy).²¹
- Treatment of ACOS should also include advice about other therapeutic strategies¹⁶ including:
 - o Smoking cessation
 - o Pulmonary rehabilitation
 - o Vaccinations
 - o Treatment of comorbidities, as advised in the respective GINA and GOLD reports.

In a majority of patients, the initial management of asthma and COPD can be satisfactorily carried out at primary care level. However, both the GINA and GOLD strategy reports make provision for referral for further diagnostic procedures at relevant points in patient management (see Step 5). This may be particularly important for patients with suspected ACOS, given that it is associated with worse outcomes and greater health care utilization.

Table 3. Spirometric measures in asthma, COPD and ACOS

| Spirometric variable | Asthma | COPD | ACOS |
|--|---|---|---|
| Normal FEV ₁ /FVC pre- or post BD | Compatible with diagnosis | Not compatible with diagnosis | Not compatible unless other evidence of chronic airflow limitation |
| Post-BD FEV ₁ /FVC <0.7 | Indicates airflow limitation but may improve spontaneously or on treatment | Required for diagnosis (GOLD) | Usually present |
| FEV ₁ ≥80% predicted | Compatible with diagnosis (good asthma control or interval between symptoms) | Compatible with GOLD classification of mild airflow limitation (categories A or B) if post- BD FEV ₁ /FVC <0.7 | Compatible with diagnosis of mild ACOS |
| FEV ₁ <80% predicted | Compatible with diagnosis. Risk factor for asthma exacerbations | An indicator of severity of airflow limitation and risk of future events (e.g. mortality and COPD exacerbations) | An indicator of severity of airflow limitation and risk of future events (e.g. mortality and exacerbations) |
| Post-BD increase in FEV ₁ >12% and 200 ml from baseline (reversible airflow limitation) | Usual at some time in course of asthma, but may not be present when well-controlled or on controllers | Common and more likely when FEV ₁ is low, but ACOS should also be considered | Common and more likely when FEV ₁ is low, but ACOS should also be considered |
| Post-BD increase in FEV ₁ >12% and 400ml from baseline (marked reversibility) | High probability of asthma | Unusual in COPD. Consider ACOS | Compatible with diagnosis of ACOS |

ACOS: asthma-COPD overlap syndrome; BD: bronchodilator; FEV₁: forced expiratory volume in 1 second; FVC: forced vital capacity; GOLD: Global Initiative for Obstructive Lung Disease.

STEP 5: Referral for specialized investigations (if necessary)

Referral for expert advice and further diagnostic evaluation is necessary in the following contexts:

- Patients with persistent symptoms and/or exacerbations despite treatment.
- Diagnostic uncertainty, especially if an alternative diagnosis (e.g. bronchiectasis, post-tuberculous scarring, bronchiolitis, pulmonary fibrosis, pulmonary hypertension, cardiovascular diseases and other causes of respiratory symptoms) needs to be excluded.
- Patients with suspected asthma or COPD in whom atypical or additional symptoms or signs (e.g. haemoptysis, significant weight loss, night sweats, fever, signs of bronchiectasis or other structural lung disease) suggest an additional pulmonary diagnosis. This should prompt early referral, without necessarily waiting for a trial of treatment for asthma or COPD.
- When chronic airways disease is suspected but syndromic features of both asthma and COPD are few.
- Patients with comorbidities that may interfere with the assessment and management of their airways disease.
- Referral may also be appropriate for issues arising during on-going management of asthma, COPD or ACOS, as outlined in the GINA and GOLD strategy reports.

Table 5 summarizes specialized investigations that may be used to distinguish asthma and COPD.

Table 4. Summary of syndromic approach to diseases of chronic airflow limitation

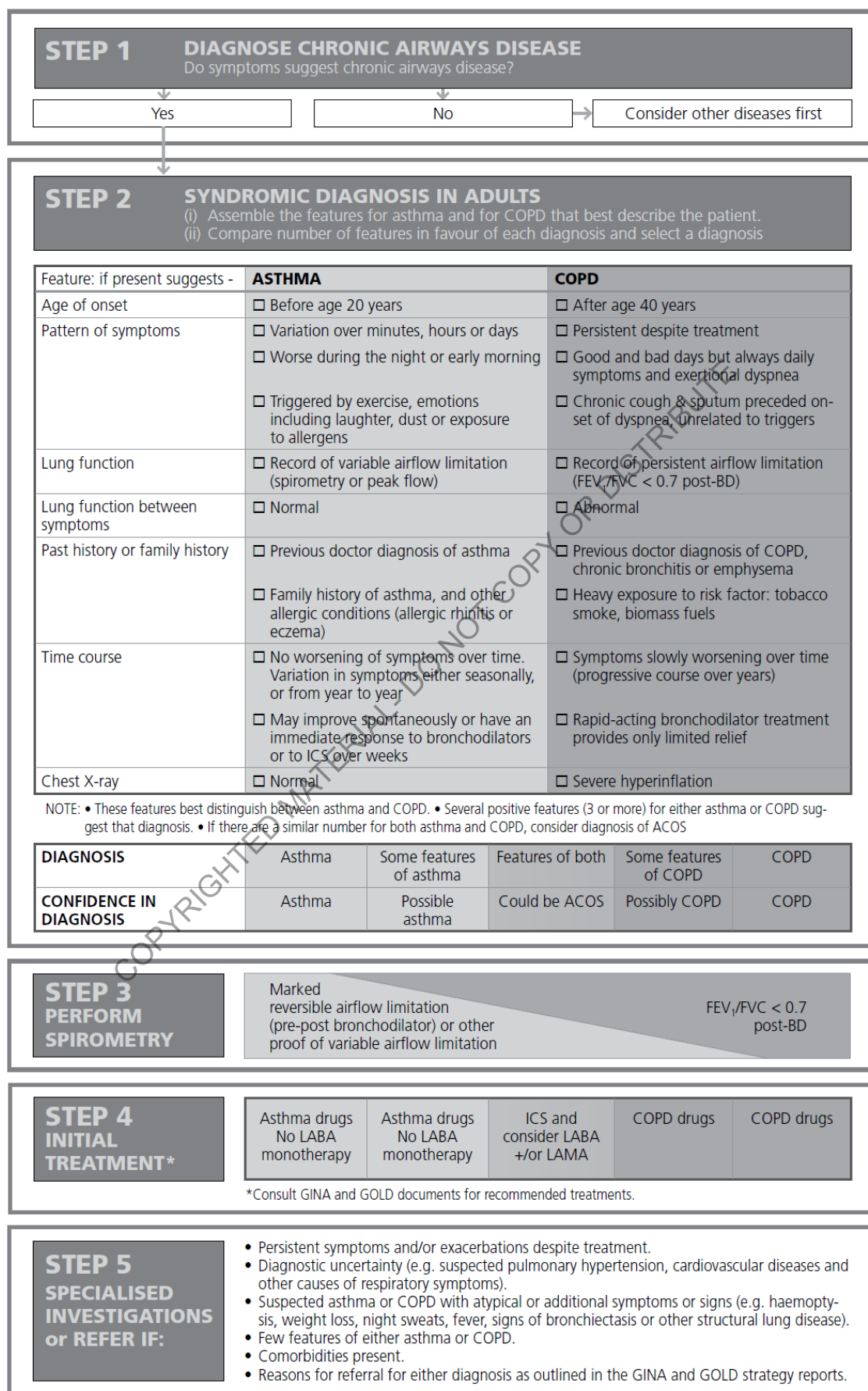


Table 5. Specialized investigations sometimes used in distinguishing asthma and COPD

| Asthma | | COPD |
|---|--|--|
| Lung function tests | | |
| DLCO | Normal (or slightly elevated). | Often reduced. |
| Arterial blood gases | Normal between exacerbations | May be chronically abnormal between exacerbations in more severe forms of COPD |
| Airway hyperresponsiveness (AHR) | Not useful on its own in distinguishing asthma from COPD, but high levels of AHR favor asthma | |
| Imaging | | |
| High resolution CT Scan | Usually normal but air trapping and increased bronchial wall thickness may be observed. | Low attenuation areas denoting either air trapping or emphysematous change can be quantitated; bronchial wall thickening and features of pulmonary hypertension may be seen. |
| Inflammatory biomarkers | | |
| Test for atopy (specific IgE and/or skin prick tests) | Modestly increases probability of asthma; not essential for diagnosis | Conforms to background prevalence; does not rule out COPD |
| FENO | A high level (>50 ppb) in non-smokers supports a diagnosis of eosinophilic airway inflammation | Usually normal. Low in current smokers. |
| Blood eosinophilia | Supports asthma diagnosis | May be present during exacerbations |
| Sputum inflammatory cell analysis | Role in differential diagnosis is not established in large populations | |

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