VI Reunión de EPOC

Casa Convalescència. Barcelona
17-18 de Marzo 2011

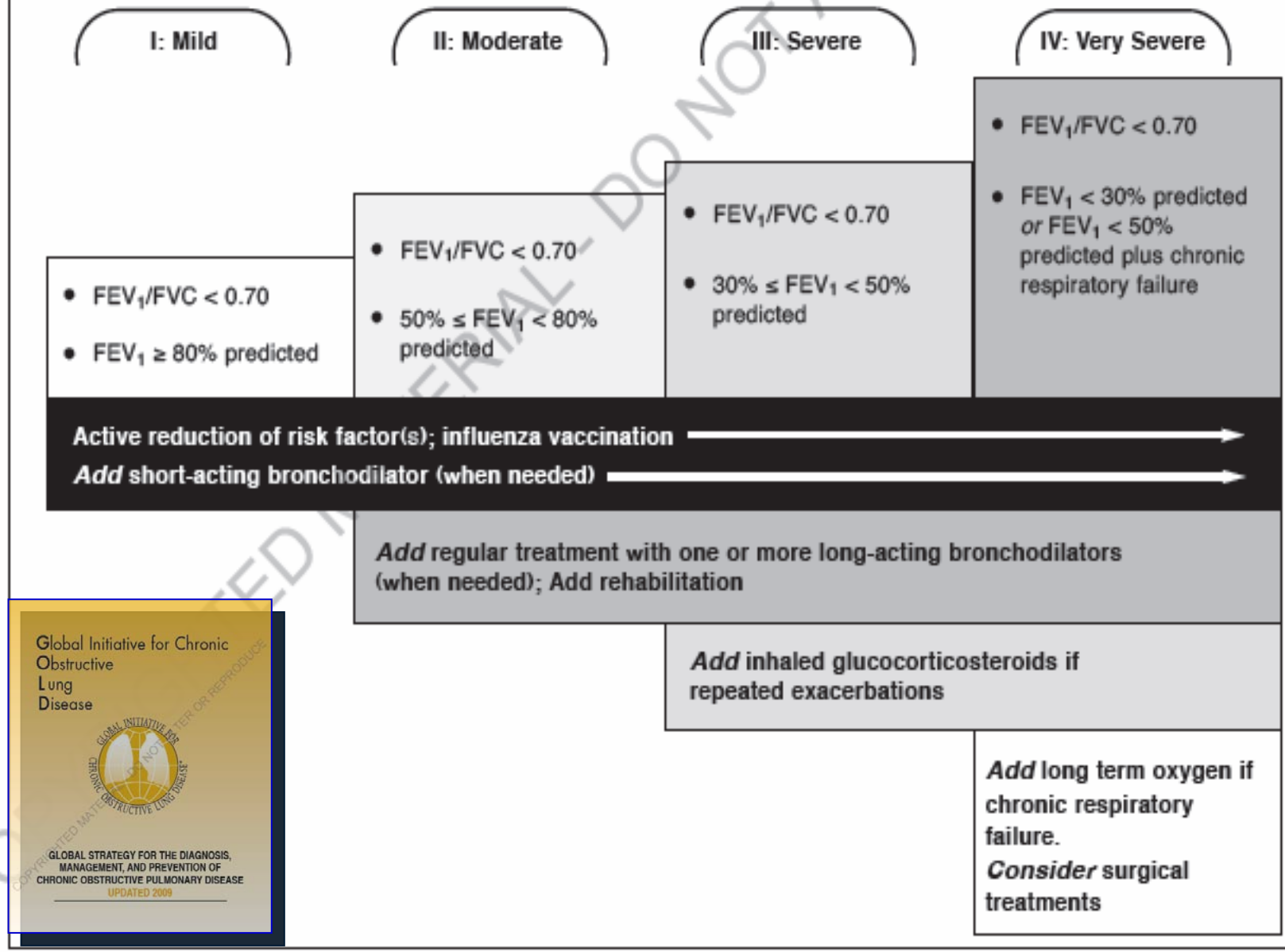
¿A quién tratar y con qué?

JC MARTÍN ESCUDERO

Guías EPOC

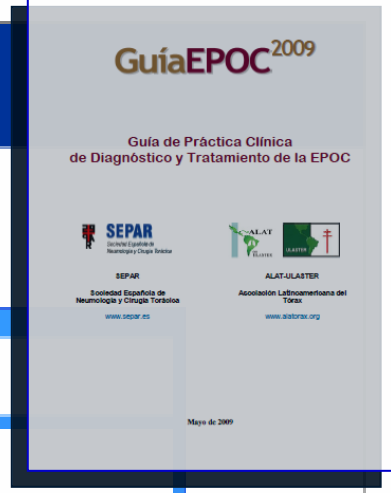

Global Initiative for Chronic Obstructive Lung Disease
GLOBAL INITIATIVE FOR CHRONIC OBSTRUCTIVE LUNG DISEASE
GLOBAL STRATEGY FOR THE
MANAGEMENT, AND PREVE
CHRONIC OBSTRUCTIVE PULMO
UPDATED 200
Enfermedad Pulmonar Obstructiva Crónica
Pautas para el mane
del paciente
EPO
GuíaEPOC 2009
Guía de Práctica Clínica
de Diagnóstico y Tratamiento de la EPOC
SEPAR
Sociedad Española de
Neumología y Cirugía Torácica
www.separ.es
ALAT-ULAETER
Asociación Latinoamericana del
Tórax
Mayo de 2009

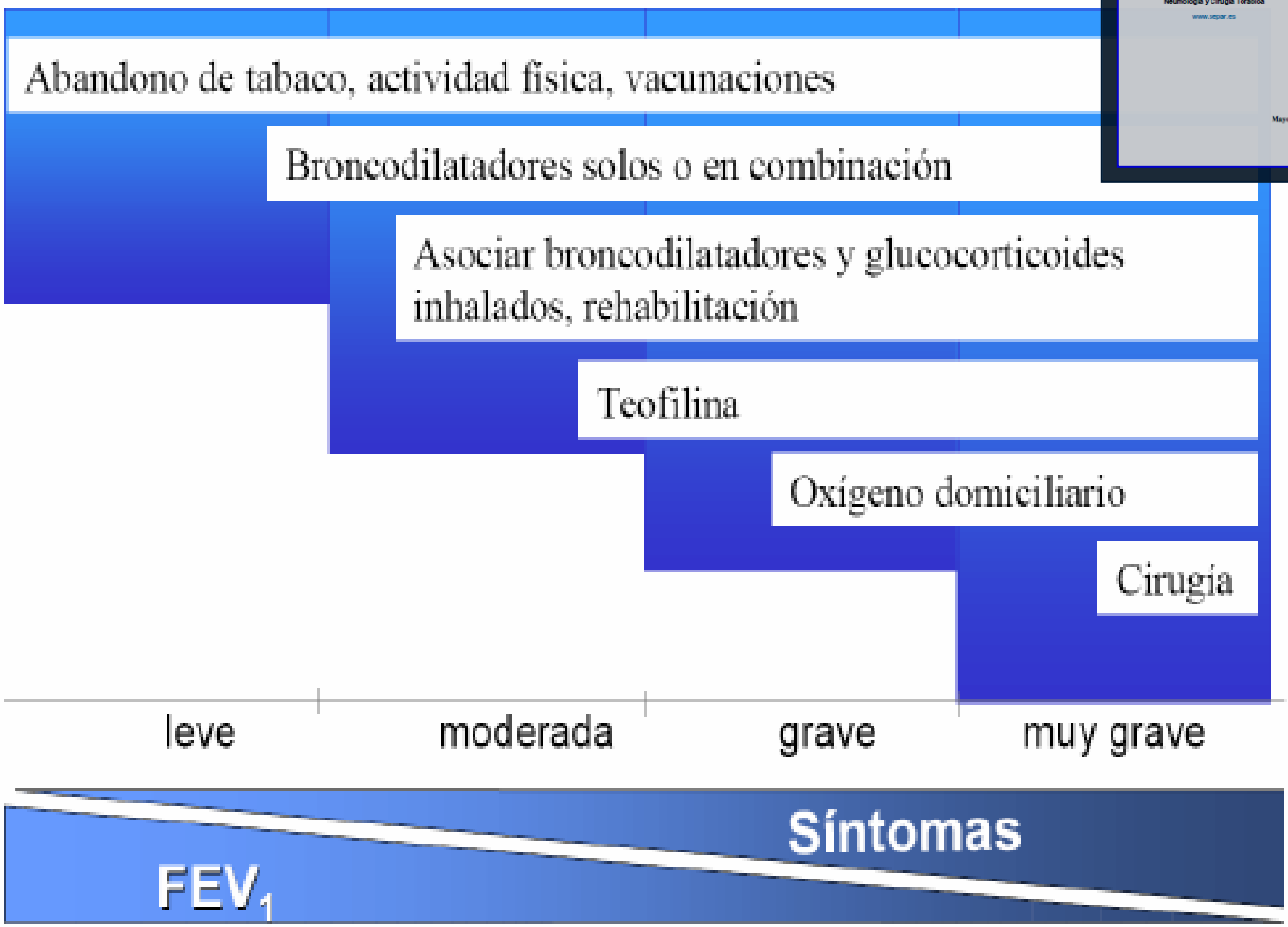
Figure 5.3-7. Therapy at Each Stage of COPD*



Postbronchodilator FEV_1 is recommended for the diagnosis and assessment of severity of COPD.

Figura 3. Tratamiento de la EPOC





National Institute for Health and Clinical Excellence (NICE) guideline

For the full versions of these articles see bmj.com

CLINICAL REVIEW

FROM *DRUG AND THERAPEUTICS BULLETIN*

Preventing exacerbations in chronic obstructive pulmonary disease

This article was originally published with the title Preventing exacerbations in COPD in *Drug and Therapeutics Bulletin* (*DTB* 2010;48:74-7).

DTB is a highly regarded source of unbiased, evidence based information and practical advice for healthcare professionals. It is independent of the pharmaceutical industry, government, and regulatory authorities, and is free of advertising. *DTB* is available online at http://dtb.bmj.com

Drug and Therapeutics Bulletin
Editorial Office, London
WC1H 9JR, UK
dtb@bmjgroup.com

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doi: 10.1136/bmj.c7207

Acute exacerbations of chronic obstructive pulmonary disease (COPD) are associated with significant morbidity and mortality. Patients with frequent exacerbations have high levels of anxiety and depression, significantly impaired health status and faster disease progression.[1 2] Exacerbations are also the most common cause of emergen ratory admissions to UK hospitals[3] and are costly services.[2] Here we assess whether and how drug drug interventions can help in preventing exacerbations.

The frequency of episodes increases with disease severity.[2] On average, people with moderate to severe COPD have around three exacerbations per year compared with an average of around two for patients with mild disease.[2]

In trials of interventions in COPD, exacerbations are sometimes defined according to severity. For example, a moderate exacerbation might be defined as a worsening of respiratory symptoms requiring treatment with an antibacterial and/or oral corticosteroid, while a severe episode is often described as one requiring hospitalisation.

Preventive measures

Single drugs

erately severe COPD) found that, compared with placebo

BMJ 2011;342: c7207

National Institute for Health and Clinical Excellence (NICE) guideline

- EPOC estable con disnea o exacerbaciones, a pesar del uso de broncodilatadores de acción corta, se debe ofrecer:
  - si FEV1 ≥50%: LABA o LAMA.
  - si FEV1 <50%: LABA+CI o LABA+LAMA.
- EPOC con disnea o exacerbaciones a pesar de tomar un LABA+CI , además LAMA, con independencia de su FEV1.
- Sin embargo, no hay pruebas suficientes del beneficio de la triple terapia.

Triple terapia: LABA + CI + LAMA

Annals of Internal Medicine | ARTICLE

Tiotropium in Combination with Placebo, Salmeterol, or Fluticasone–Salmeterol for Treatment of Chronic Obstructive Pulmonary Disease

A Randomized Trial

Shawn D. Aaron, MD; Katherine L. Vandemheen, BScN; Dean Fergusson, PhD; François Maltais, MD; Jean Bourbeau, MD; Roger Goldstein, MD; Meyer Balter, MD; Denis O'Donnell, MD; Andrew McIvor, MD; Sat Sharma, MD; Graham Bishop, MD; John Anthony, MD; Robert Cowie, MD; Stephen Field, MD; Andrew Hirsch, MD; Paul Hernandez, MD; Robert Rivington, MD; Jeremy Road, MD; Victor Hoffstein, MD; Richard Hodder, MD; Darcy Marciniuk, MD; David McCormack, MD; George Fox, MD; Gerard Cox, MB; Henry B. Prins, MD; Gordon Ford, MD; Dominique Bleskie, BHScN; Steve Doucette, MSc; Irvin Mayers, MD; Kenneth Chapman, MD; Noe Zamel, MD; and Mark FitzGerald, MD, for the Canadian Thoracic Society/Canadian Respiratory Clinical Research Consortium

Conclusiones: La adición de fluticasona-salmeterol a tiotropio no influye en las tasas de exacerbación de la EPOC, pero mejora la función pulmonar, la calidad de vida, y las tasas de hospitalización en pacientes con EPOC moderada a grave.

ECLIPSE

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Susceptibility to Exacerbation in Chronic Obstructive Pulmonary Disease

John R. Hurst, M.B., Ch.B., Ph.D., Jørgen Vestbo, M.D., Antonio Anzueto, M.D., Nicholas Locantore, Ph.D., Hana Müllerova, Ph.D., Ruth Tal-Singer, Ph.D., Bruce Miller, Ph.D., David A. Lomas, Ph.D., Alvar Agusti, M.D., Ph.D., William MacNee, M.B., Ch.B., M.D., Peter Calverley, M.D., Stephen Rennard, M.D., Emiel F.M. Wouters, M.D., Ph.D., and Jadwiga A. Wedzicha, M.D., for the Evaluation of COPD Longitudinally to Identify Predictive Surrogate Endpoints (ECLIPSE) Investigators*

Agusti *et al. Respiratory Research* 2010, **11**:122
http://respiratory-research.com/content/11/1/122

RESPIRATORY RESEARCH

RESEARCH Open Access

Characterisation of COPD heterogeneity in the ECLIPSE cohort

Alvar Agusti[1*], Peter MA Calverley[2], Bartolome Celli[3], Harvey O Coxson[4], Lisa D Edwards[5], David A Lomas[6], William MacNee[7], Bruce E Miller[8], Steve Rennard[9], Edwin K Silverman[10], Ruth Tal-Singer[8], Emiel Wouters[11], Julie C Yates[5], Jørgen Vestbo[12],
the Evaluation of COPD Longitudinally to Identify Predictive Surrogate Endpoints (ECLIPSE) investigators

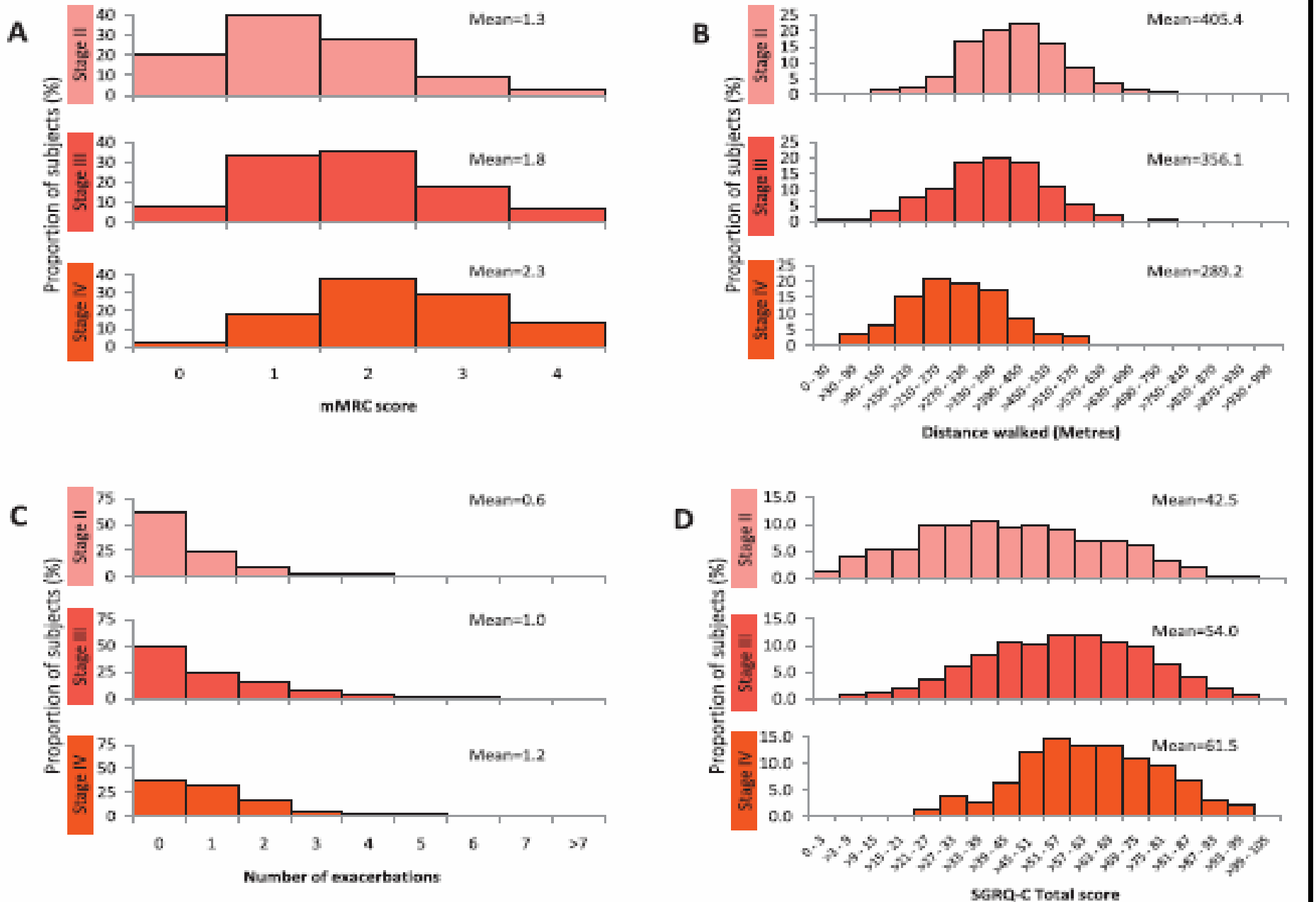
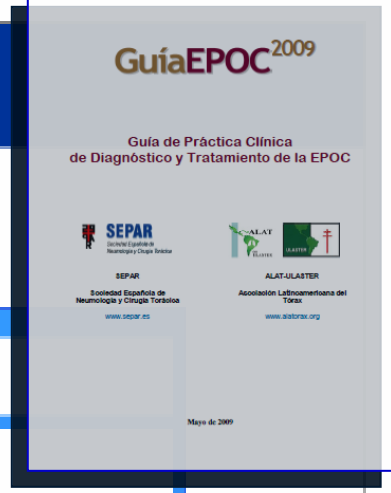
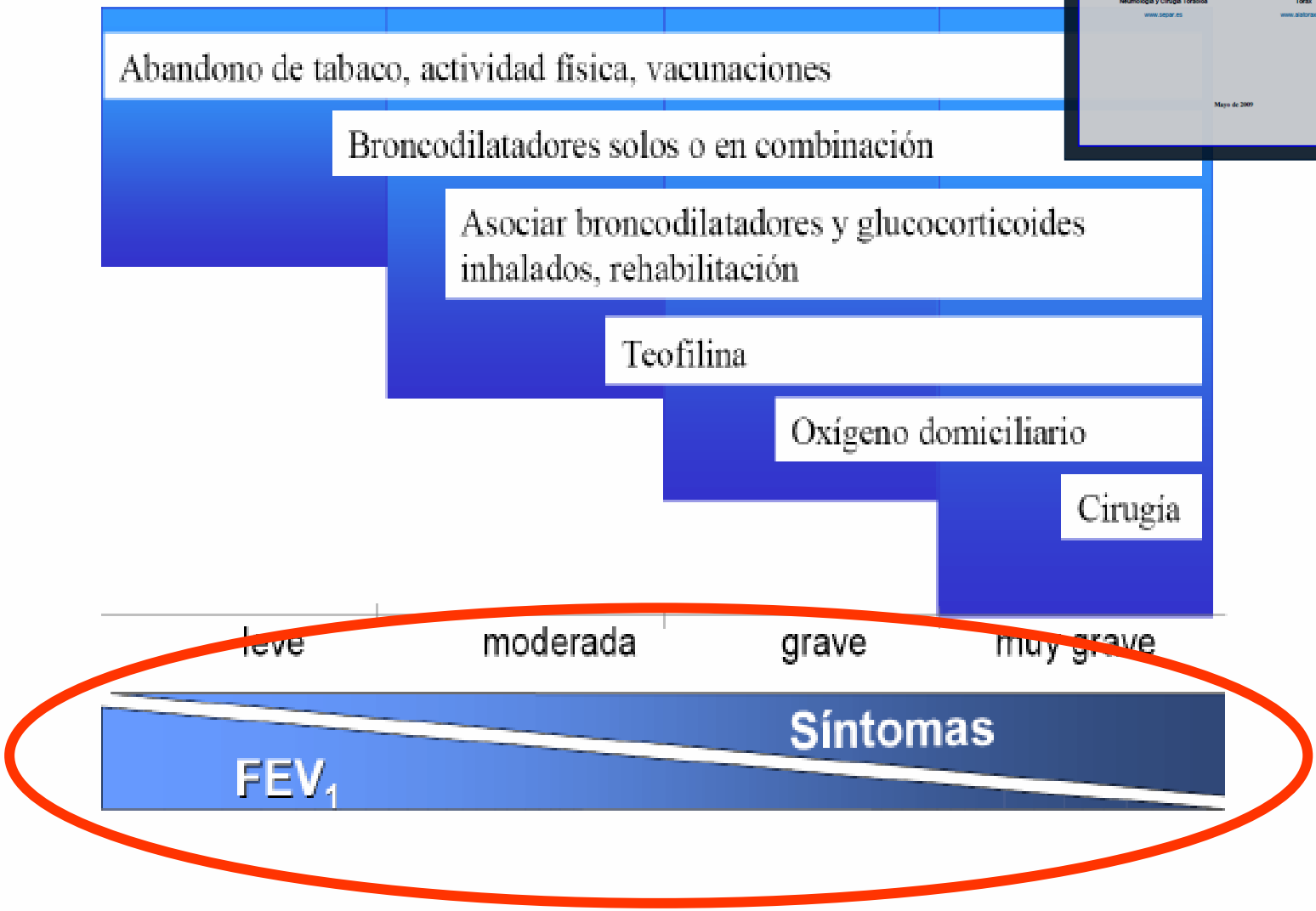


Figure 4 Frequency distribution of the breathlessness as assessed by the mMRC questionnaire (panel A), exercise capacity as assessed by the 6MWD (panel B), reported exacerbations in the year before inclusion in the study (panel C), and health status assessed by SGRQ-C (panel D) according to severity of disease. For further explanations see text.

Figura 3. Tratamiento de la EPOC





Guías EPOC

ECLIPSE

Consenso de expertos

- FEV1 por sí solo, no describe adecuadamente la complejidad de la enfermedad.
- FEV1 no se debe utilizar de forma aislada para el diagnóstico, evaluación y manejo óptimo de la enfermedad.

Una muy buena propuesta:

Arch Bronconeumol. 2009; 45(Supl 5): 27-34

ELSEVIER DOYMA

Archivos de Bronconeumología

www.archbronconeumol.org

Tratamiento individualizado de la EPOC: una propuesta de cambio

Marc Miravitlles

Fundació Clínic, Institut d'Investigacions Biomèdiques August Pi i Sunyer (IDIBAPS), Barcelona, España

Arch Bronconeumol. 2009; 45(Supl 5): 27-34

Tipos Clínicos o “Fenotipos”

- tipo A: enfisema.
- tipo B: bronquitis crónica.
- tipo C: enfisema con afectación bronquial crónica (mixto).
- tipo D: fumador con asma crónica.
- tipo E: asma con bronquitis crónica.

Arch Bronconeumol. 2009; 45(Supl 5): 27-34

Corticoides Inhalados (CI)

- No evidencia de que dosis altas sea mejor.
- Si CI siempre asociados a LABA.
- Recomendables en “agudizadores frecuentes” (>2/año).
- Recomendables en “rasgos asmáticos” (D, E)
- Sea cual sea su FEV1.
- En el resto mínimo beneficio.

Arch Bronconeumol. 2009; 45(Supl 5): 27-34

Broncodilatadores de corta duración.

- No son un tratamiento de mantenimiento en EPOC.
- Solo uso a demanda o en agudizaciones.

Arch Bronconeumol. 2009; 45(Supl 5): 27-34

Tratamiento EPOC

- Tratamiento inicial en todos: LABA o LAMA.
- Si no es suficiente: LABA+LAMA.
- Si no suficiente: LABA+LAMA +Teofilina.
- Fenotipo Bronquitis crónica y exacerbador, si FEV1<50% : añadir Roflumilast.

Arch Bronconeumol. 2009; 45(Supl 5): 27-34

¿Triple terapia?

- En los pacientes más graves se puede ensayar el uso de LAMA+ LABA+CI.
- No es aceptable recomendar tratamiento triple con LAMA + LABA + CI como estándar, ni siquiera en EPOC grave.

Arch Bronconeumol. 2009; 45(Supl 5): 27-34

- *"Ya no existe un tratamiento de la EPOC, sino que, al igual que ocurre con otras enfermedades crónicas como la hipertensión o la diabetes, las diversas opciones terapéuticas deben individualizarse en función de las características de cada paciente".* Marc Miravitlles

Arch Bronconeumol. 2009; 45 (Supl 5): 27-34


CABELLO
16/06/2005